

UNDERSTANDING HOW PRIMARY CARE PHYSICIANS WORK WITH  
PERSONALITY DISORDER PATIENTS: A QUALITATIVE APPROACH

A Dissertation

by

JAMES DEEGEAR

Submitted to the Office of Graduate Studies of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

August 2004

Major Subject: Counseling Psychology

UNDERSTANDING HOW PRIMARY CARE PHYSICIANS WORK WITH  
PERSONALITY DISORDER PATIENTS: A QUALITATIVE APPROACH

A Dissertation

by

JAMES DEEGEAR

Submitted to Texas A&M University  
in partial fulfillment of the requirements  
for the degree of

DOCTOR OF PHILOSOPHY

Approved as to style and content by:

---

David Lawson  
(Chair of Committee)

---

Richard DeVaul  
(Member)

---

Dan Brossart  
(Member)

---

Michael Duffy  
(Member)

---

Victor Willson  
(Head of Department)

August 2004

Major Subject: Counseling Psychology

## ABSTRACT

Understanding How Primary Care Physicians Work with  
Personality Disorder Patients: A Qualitative Approach. (August 2004)

James Deegear, B.A., Washington and Lee University;

M.A., Trinity University

Chair of Advisory Committee: Dr. David Lawson

The purpose of the present study was to begin to develop an understanding of how primary care resident physicians work with patients with personality disorder-type characteristics and processes. Participants include fifteen primary care resident physicians from a community health clinic. Participants individually viewed two video vignettes of an actor-patient being interviewed by a physician. Participants were asked how they would respond to statements the actor-patient made during the course of watching the video and then answered general questions about reactions to the actor-patient and working with patients with personality disorders.

Using a naturalistic qualitative analysis, data were analyzed for categories and themes. The results of the analyses are presented within a basic framework for understanding how primary care residents work with and approach the doctor-patient relationship, and treat patients with personality disorder characteristics and associated personality processes.

Broad themes emerge from the data. Content of residents' responses suggests two response styles: attention to patient's presenting physical concern or identify and

potentially address underlying psychological and emotional concerns. Residents characterize the establishment of a relationship with this patient population as either a distancing, paternalistic approach, or an engaging and collegial relationship. Levels of self-awareness of reactions to patients consist of either a willingness to address personal reactions or a tendency to not identify or discuss those reactions. Residents also demonstrate a dichotomous response to willingness to work with this patient population characterized by either hesitancy to do so, or a desire to engage and attempt to work with these patients.

A framework for understanding the possible effects and motivating variables behind these styles is presented. The predominant effects of the residents' interaction styles are either a distancing/paternalistic relationship or an engaging/collegial relationship. Two themes appear to characterize residents' motivations: the resident was driven by self-needs or patient-needs.

These results may be useful in developing an initial theory of this previously unexamined dynamic. Moreover, these results may be useful in helping physicians better develop relationships with patients, especially through improvement in recognizing and utilizing personal reaction to patients. Future inquiries directed towards understanding what physician variables contribute to these two basic interaction styles identified here may be useful.

## DEDICATION

This dissertation is dedicated to my youngest sister, Cindy. Her own experiences with physicians during her struggle with cystic fibrosis served as inspiration for me in trying to learn more about the mutual impact of patient and physician. Although Cindy does not have a personality disorder, other than those usually attributed to younger siblings, I have been struck by the effect she has had on her physicians and the effect they have had on her – conscious or unconscious though these effects may be. In the interactions I have seen, it has seemed to me that the quality of the relationship has had direct bearing on contentedness and treatment. I hope that this research may have some impact on medical education that will highlight this important dynamic and improve relational interactions of between doctors and patients.

## ACKNOWLEDGEMENTS

First, I am very grateful for all of the guidance, mentoring and help of Dr. Lawson. He consistently provided encouragement, insight, and support each step of the way and was immensely helpful as I pulled everything together at the end when I needed time, motivation and validation. Dr. DeVaul helped me to understand the nature of practicing medicine and gain insight into the perspective of physicians. He also helped me gain access to the participants in the study and gave significant amounts of his time in auditing all of the data and results. Dr. Duffy and Dr. Brossart also provided wonderful insight and very strategic changes to the design of the study. Dr. Davenport graciously stepped in at the end to substitute for a committee member for the defense; her unique thoughts during the defense were very valuable additions to my understanding of the material.

Second, I want to acknowledge the support and encouragement of my family. My mother, who has always, always had great belief in me, and Toby, who consistently reminds me of the importance of simplicity and priorities. My dad, who has always been a dad, a friend, a mentor, and an inspiration, has helped me keep perspective and humor through this process (and no newly flattened fingers) and Pam, who, with calming and insightful words, can turn any rainy day into sunshine. Scotty, my other sister, has continuously called to check on me and provided encouragement during some of my more challenging times. Then, of course, there are my in-laws: one who reminds me of the simple laws of life (i.e., if you work at it, you will finish, if you don't, you won't) and the other who has introduced me to the great need for geriatric services – they know

which is which. My wife, Kellie, moved and changed jobs to help me through graduate school and has supported me with unwavering encouragement, love, time and understanding. Not only did she help me earn a doctoral degree, she brought our daughter, Emma Reese, into our lives during this time.

Finally, I am very grateful for the time and effort and insights of the residents who participated in this study as well as the Brazos Valley Residency Program that provided me access to the residents.

## TABLE OF CONTENTS

	Page
ABSTRACT.....	iii
DEDICATION .....	v
ACKNOWLEDGEMENTS.....	vi
TABLE OF CONTENTS .....	viii
LIST OF TABLES .....	xiii
LIST OF FIGURES.....	xiv
CHAPTER	
I INTRODUCTION.....	1
Statement of the Focus of Inquiry .....	3
Focus of Inquiry Research Questions .....	4
Using Naturalistic Inquiry.....	5
Definition of Terms .....	5
Limitations of the Study.....	7
II REVIEW OF THE LITERATURE.....	9
The Importance of the Doctor-Patient Relationship in Treating Illness .....	9
The Role of Personality Variables in Illness.....	12
Physician-Patient Alliance and Personality Disorder .....	16
Personality Disorder Defined.....	17
Effects of Personality Disorders on Doctor-Patient Relationships .....	20
Prevalence of Personality Disorders in the Medical Setting and Rate of Diagnosis .....	24
Recognizing Personality Disorders in Primary Care Settings .....	29
The Need for Doctors to Identify Personality Factors in Treating Patients.....	33
Training Physicians to Recognize Personality Disorders .....	41
Summary .....	45
Qualitative Research.....	46
Statement of the Focus of Inquiry .....	48



CHAPTER		Page
	Focus of Inquiry Research Questions .....	49
III	METHODOLOGY .....	50
	Purpose.....	50
	Use of Qualitative Methods .....	50
	General Description of the Study .....	52
	The Video.....	54
	The Dependent-Overdemanding Personality and Personality Disorders .....	56
	The Guarded-Querulous Personality and Personality Disorders .....	57
	Key Informant Interviews .....	58
	Participants.....	60
	Interview Format .....	63
	Confidentiality.....	64
	Instrument .....	65
	Analysis – Overview of Constant-Comparative Methodology .....	67
	Analysis – Establishing Trustworthiness .....	74
	Changes in the Focus of the Study .....	79
	How the Analyses Unfolded .....	80
	Audit of the Analysis .....	82
IV	RESULTS .....	83
	Overview of the Levels of Analysis and Interpretation.....	83
	How the Results are Presented .....	85
	Focus of Inquiry Research Question 1A.....	88
	Focus of Inquiry Research Question 1B .....	91
	Summary of Results of Focus of Inquiry Research Question 1 .....	95
	Focus of Inquiry Research Question 2.....	96
	Summary of Results of Focus of Inquiry Research Question 2 .....	102
	Focus of Inquiry Research Question 3.....	103
	Summary of Results of Focus of Inquiry Research Question 3 .....	110
	Focus of Inquiry Research Question 4.....	111
	Summary of Results of Focus of Inquiry Research Question 4 .....	113

CHAPTER		Page
V	CONCLUSIONS.....	114
	Overview of Conclusions Section .....	114
	A Comprehensive Framework.....	115
	Possible Thematic Effects of the Responses .....	116
	Possible Thematic Motives of the Responses .....	125
	Impact of Self-Awareness .....	130
	Consistency of Residents' Responses.....	133
	Do Residents Demonstrate Consistency Between Their Ideas and What They Did? .....	135
	Comparison of Findings with the Literature .....	139
	Possible Implications for Medical Education.....	141
	Limitations of the Study and Areas for Further Consideration .....	144
	Summary .....	147
	REFERENCES.....	150
APPENDIX A	INTERVIEW QUESTIONS .....	158
APPENDIX B	QUESTIONS ADDED DURING THE COURSE OF THE INVESTIGATION .....	161
APPENDIX C	LETTER OF ATTESTATION FROM AUDITOR.....	162
APPENDIX D	FOCUS OF INQUIRY RESEARCH QUESTIONS AND SPECIFIC INTERVIEW QUESTIONS USED IN THE ANALYSIS .....	163
APPENDIX E	PATIENT-COMPLAINT ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A.....	165
APPENDIX F	PATIENT-DYNAMIC ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A.....	166
APPENDIX G	PATIENT-COMPLAINT ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B.....	167
APPENDIX H	PATIENT-DYNAMIC ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B.....	168
APPENDIX I	PATIENT-COMPLAINT ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 .....	169

APPENDIX J	PATIENT-DYNAMIC ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 .....	170
APPENDIX K	PATIENT-ONLY REACTION ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 .....	171
APPENDIX L	SELF-AWARENESS ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 .....	172
APPENDIX M	UNWILLINGNESS / HESITANT ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 4...	173
APPENDIX N	WILLINGNESS / OPENNESS ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 4 .....	174
APPENDIX O	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A V1Q1 .....	175
APPENDIX P	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A V1Q2 .....	181
APPENDIX Q	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A V1Q3 .....	188
APPENDIX R	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q1 .....	193
APPENDIX S	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q2 .....	200
APPENDIX T	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q4 .....	208
APPENDIX U	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 V1Q10 .....	214
APPENDIX V	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 V2Q10 .....	221
APPENDIX W	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 GQE1 .....	227
APPENDIX X	CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 GQE2 .....	230

	Page
APPENDIX Y	
CATEGORIES FOR FOCUS OF INQUIRY RESEARCH	
QUESTION 3 V1Q6.....	238
APPENDIX Z	
CATEGORIES FOR FOCUS OF INQUIRY RESEARCH	
QUESTION 3 V1Q7.....	247
APPENDIX AA	
CATEGORIES FOR FOCUS OF INQUIRY RESEARCH	
QUESTION 3 V2Q6.....	254
APPENDIX AB	
CATEGORIES FOR FOCUS OF INQUIRY RESEARCH	
QUESTION 3 V2Q7.....	261
APPENDIX AC	
CATEGORIES FOR FOCUS OF INQUIRY RESEARCH	
QUESTION 4 GQ1.....	268
APPENDIX AD	
RESIDENTS' RESPONSE STYLES BY INTERVIEW	
QUESTION.....	276
VITA.....	291

## LIST OF TABLES

TABLE		Page
1	Consistency of Resident Response Styles .....	134
2	Consistency Between Ideas and Responses.....	136

## LIST OF FIGURES

FIGURE		Page
1	Continuum of Response Themes: Complaint vs. Dynamic.....	84
2	Continuum of Response Themes: Patient-Only Reaction vs. Self Awareness Reaction.....	105
3	Continuum of Response Themes: Unwilling vs. Willing.....	113
4	Continuum of Response Effect: Distancing vs. Engaging .....	117
5	Continuum of Response Themes: Physician Needs vs. Patient Needs .....	126

## CHAPTER I

### INTRODUCTION

In his book *Healing and the Mind*, Bill Moyers (1993) interviews Thomas Delbanco, M.D., Director of the Division of General Medicine and Primary Care at Beth Israel Hospital in Boston, Associate Professor of Medicine at Harvard Medical School, and Director of the Picker/Commonwealth Program for Patient-Centered Care. In the interview, Delbanco speaks to the importance of treating patients as unique individuals and of developing a working knowledge of each patient. In describing his approach to working with patients, he states,

I want to know what they bring to the table. I want to know what they want from me. I want to know what kind of person they are like, so I'll know how they filter what I say...I find myself a very different person with different patients...I've got to know what makes you tick. I may know a lot about your disease, but I don't know how you experience your illness. The attitude with which you confront your illness will make a real difference in how you do over time. (pp. 8 – 14)

Helman (1985) echoes Delbanco's perspective of illness as the multifaceted process of disease impacting an individual. Noting that illness "refers to the subjective response of the patient, and those around him, to an episode of ill-health" (p. 923), he conceptualizes illness as a "more diffuse concept patterned by social, psychological and cultural factors" (p. 923).

---

This dissertation follows the style of *Health Psychology*.

Given this important awareness that the physician work with the whole patient and not simply the patient's disease, it would seem important that the physician recognize, understand, and work with the personality variables that impact the unique "illness experience" of the patient. Moreover, research has identified the importance of the physician-patient relationship in medical treatment (Krupnick et al., 1996; Scovern, 2000). The relationship, of course, is established between two people, each with her or his own personality dynamics that affect the establishment and growth of that relationship. Individuals with personality disorder-type characteristics and processes often demonstrate distorted images of self and chaotic interaction styles. In the medical literature, these have been described as obnoxious, crock, hateful and difficult (Groves, 1978) and others (e.g., Pare & Rosenbluth, 1999) have underscored the difficulties in working with these patients. As such, establishing an effective physician-patient relationship as part of comprehensive treatment may be complicated by the presence of personality disorder-type characteristics and processes.

The literature has demonstrated that physicians can frequently miss the appropriate diagnosis of a personality disorder, with up to 50% of psychiatric and psychosocial problems being missed by physicians (Stewart, 1995). In addition to attending to the standard criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*, American Psychiatric Association (APA), 1994), it has been recommended that physicians attend to their own personal reactions to patients as a means to identifying patient personality variables (e.g., Bibring, 1964; Groves, 1978; Schafer & Nowlis, 1998).



### *Statement of the Focus of Inquiry*

While the literature addresses what personality disorders look like, their effect on physicians, the rate of accurate diagnosis in medical settings, and the importance of what to attend to in making such a diagnosis, there has been no effort to develop an understanding of how physicians actually work with these patients – *what these interactions look like*. This study will address how physicians work with patients with personality disorders. The focus will seek to explore how physicians identify, understand, and approach patients with personality disorder-type characteristics and processes in a primary care setting, specifically dependent-type and guarded/querulous-type personality styles.

The focus on the dependent-type and guarded/querulous-type personality styles arose out of necessity in developing this study. To achieve the best approximation of a physician-patient interaction (due to the inability to observe actual doctor-patient interactions), I used a video vignette of an actor patient and participants were asked to respond to specific statements made by the actor-patient in the video and then to interview questions about the participant's reaction to the actor-patient in the video as well as general questions about working with patients. However, in trying to identify a suitable video for the study, I was only able to find one such tool. Discussed at greater length in Chapter III, the video's vignettes are based on a personality nosology established by Kahana and Bibring (1964). However, despite being an older nosology, the personality types they describe are still used in medical education today. The video, developed Dr. Drossman (Professor of Medicine and Psychiatry at the University of North Carolina at Chapel Hill, School of Medicine), utilizes this nosology. Moreover,

Miller (2001) draws upon the Kahana and Bibring nosology in his article that discusses an expanded version of personality types described by Kahana and Bibring that “coincide roughly with DSM-IV Axis II personality disorders” (§ 10). Thus, I believe that the format for this study provides the best approximation for developing a description and basic initial understanding of how physicians work with patients with personality disorder-type characteristics and processes.

*Focus of Inquiry Research Questions*

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:
  - a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.
  - b. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/querulous or paranoid type) characteristics and processes.
2. What are some themes suggestive of resident primary care physicians’ characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles?
3. What are some themes suggestive of how resident primary care physicians’ characterize their reactions to patients with personality disorder-type

characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles?

4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles, in primary care settings?

### *Using Naturalistic Inquiry*

To research a previously unexplored area, a naturalistic inquiry of qualitative methodology was chosen. According to Hill, Thompson and Williams (1997), the use of qualitative methodologies are particularly useful in researching topics previously not examined. Moreover, Kuzel (1998) has championed the particular usefulness of qualitative research within medical settings. Following Lincoln and Guba's (1985) outline of naturalistic inquiry, the present study seeks to utilize a grounded theory approach to the development of a framework for considering how resident primary care physicians work with these patients and approach the relationship with and treatment of these patients.

### *Definition of Terms*

There are some basic terms used in various parts of this study that deserve some clarification here.

1. Dependent-Type Personality (Kahana & Bibring, 1964) is used to describe an individual with a seemingly insatiable need for attention and care. Driven by a basic self-perception of helplessness, this individual may initially idealize others with the hope that they will fulfill all his caretaking needs. However, if early

experiences resulted in feelings of disappointment, there may be an underlying anticipation of rejection, leading to a demanding and revengeful style in an effort to win attention and have needs met. Perhaps the DSM-IV (APA, 1994) diagnosis of Dependent Personality Disorder best approximates this personality type.

2. Guarded/Querulous-Type Personality (Kahana & Bibring, 1964) is used to describe a person who tends to be paranoid and suspicious of others. This personality style may tend to be defensive towards others out of fear of being hurt or taken advantage of. Individuals with this personality style may be prone to abnormal reactions to perceived slights from others or negative feelings perceived in others. Instead of acknowledging any inner problems, unwanted characteristics are projected onto others who are then seen as threatening and bad. Perhaps the DSM-IV (APA, 1994) classification of Borderline Personality Disorder best approximates this personality style.
3. Naturalistic Inquiry (Lincoln & Guba, 1985) describes a research methodology that implies that the researcher does not manipulate what is being researched and the researcher expresses no bias or suggestion as to what the outcome of the investigation will be. Other terms identified by Lincoln and Guba that are synonymous with Naturalistic Inquiry are: postpositivistic, ethnographic, phenomenological, subjective, case study, qualitative, hermeneutic, and humanistic.

4. Focus of Inquiry Research Question is a term used in naturalistic research to identify the primary target of the research. The analog term in quantitative methods is “Research Question.”
5. Personality Disorder-Type Characteristics and Processes is used here to identify those traits that are typically associated with personality disorders. Because, as discussed above, a pure representation of a personality disorder is not utilized in this investigation, a more accurate description of “characteristics and processes” that typify the personality disordered individual is warranted.

### *Limitations of the Study*

1. The main limitation, as noted earlier, is that I could not observe an actual interaction between a physician and a patient. The use of video-vignettes to investigate this dynamic do not allow for the same types of interaction and immediacy available in face-to-face interactions.
2. This study does not include an investigation of any variables that would be unique to each participant that may have influenced response styles. The investigation purely considers the responses of the participants with some suggestion as to what *may* have influenced their responses. Without specific participant-related data, definitive correlations between participant variables and responses may not be determined.
3. Given that the analysis is based on my reading and interpretation of the data, the results and conclusions are subject to my own assumptions, personality, and ideas. I have striven to follow the rigor of naturalistic inquiry set forth by Lincoln and Guba (1985) and the results have been audited by a physician familiar with the

subject and context of the study to ameliorate the effects of my influence upon analysis and interpretations. Nonetheless, the human factor in this type of research cannot be completely eliminated. Other readers of the same data will invariably draw different conclusions about the themes and categories I have identified as well as different conclusions about the effects of the response styles and possible underlying influences on respondents.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### *The Importance of the Doctor-Patient Relationship in Treating Illness*

To know a patient's illness experience is, in part, knowing the psychological dynamics of the patient. One way to have that kind of understanding of a patient is through a trusting relationship with the patient in which he/she may genuinely share thoughts, emotions, and behaviors associated with his/her illness. Following this model of utilizing the relationship as an essential component of working with patients, Scovern (2000) notes that Delbanco's statement suggests that elements of the doctor-patient relationship are similar to the therapeutic alliance established between psychotherapists and their clients. In fact, Scovern states that the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Krupnick et al., 1996) found evidence that "the therapeutic alliance is equally powerful a predictor of outcome in medical/pharmacological treatment" as in psychotherapy (p. 264). Indicative of the therapeutic alliance formed in such psychotherapeutic relationships, the relationship between physician and patient subsumes similar characteristics. Rapport, a collaborative, working relationship, empathy, and utilization of the patient's assumptive world in approaching treatment of an illness become essential aspects of the doctor-patient relationship. Specifically, Scovern comments that, "the doctor-patient relationship has, as a nonspecific factor in the treatment, some direct bearing on outcome in medicine" (p. 264). Thus, across healthcare settings (psychological and medical), the nature of the

relationship between a person in need and a healthcare provider (therapist or physician) is a critical aspect of the treatment of the patient and, potentially, his or her prognosis.

In order for this relationship to achieve maximum potency, however, it must be acknowledged and attended to by the physician. As such, Scovern (2000) suggests shifting the focus of medical treatment from an interaction between physician and disease to physician and an *ill patient*. Such a paradigm shift highlights the importance of the nature of interactions between doctor and patient. In treating an “ill patient” rather than a disease, the doctor now enters into a dynamic relationship whereby the patient presents not just with a disease, but also a unique personality, cultural experience, and personal history, in addition to idiosyncratic needs and wishes. Whereas relating to a disease consists of a doctor acting upon symptoms and pathology, relating to a patient and his or her illness creates the opportunity for exchange and mutual impact for both members of the relationship: as the physician impacts the patient, the patient impacts the physician.

Stewart (1995) discusses the need to establish a good working relationship between doctor and patient so that this relationship results in positive effects upon doctor, patient, and illness. Stewart contends that effective communication between doctor and patient is essential in establishing this relationship, noting the benefits of effective communication as “a positive influence not only on the emotional health of the patient, but also on symptom resolution, functional and physiologic status and pain control” (p. 1429). Stewart notes that the absence of such communication, of an impotent or conflicting relationship, not only damages the alliance between doctor and patient, but has resulted in complaints to licensing boards and public-relations nightmares for doctors.



Stewart (1995) states that attention to the patient's emotional well-being, involvement of the patient in identification and treatment of the disease, and the development of an understanding of the patient's expectations for treatment are necessary elements of sound practice. To achieve such sound practice physicians must establish effective, meaningful interactions with their patients. One study demonstrating the importance of effective doctor-patient relationship is evident in Smith et al. (1995). The study sought to assess the effect upon patient satisfaction of intensive, directed psychosocial training (i.e., improved communication) for resident physicians. Residents were trained in psychosocial approaches with patients with the dependent variable being change in patients' satisfaction ratings of interactions with their physicians. The results indicate that the psychosocial training had positive impacts upon factors correlated with patient satisfaction, including "patient-centered interviewing, informing patients, relationship building, and personal warmth and confidence" (p. 731). Therefore, attention to important psychosocial variables in working with patients, namely effective communication, interpersonal style and relational variables, are demonstrated to be important determinants of patients' satisfaction with their health care.

In addition to its impact on patient satisfaction, the doctor-patient relationship is an important determinant in the course of illness and outcome of treatment (Greenberg, 2000). The relationship may affect the patient's tendency to trust the doctor, to follow prescribed treatment protocols, and influence the capacity to take responsibility for changing behaviors that contribute to disease. It is incumbent upon the doctor to understand the way a patient interprets and responds to the environment (the doctor being a part of that environment) and how, as Delbanco suggests, that patient experiences

illness. In the absence of a collaborative, trusting relationship, the patient may not fully or accurately portray illness experiences, may not fully trust or believe in treatment protocols, and/or may not follow through with the prescribed treatment. By developing an understanding of the patient's personality and assumptive world, the doctor may establish a more effective relationship for working with the patient and treating his or her illness.

Thus, it has been established that the doctor-patient relationship is an essential component of treatment that should be attended to by the physician. Establishing a trusting, collaborative, and therapeutic relationship assists the physician in understanding how the patient experiences his/her illness. Moreover, these variables are shown to positively impact patient satisfaction, patient well-being, and treatment outcome.

#### *The Role of Personality Variables in Illness*

The observed link between personality and disease extends back to the days of Ancient Greece (Friedman & Booth-Kewley, 1987). Hippocrates first identified the four bodily humors that formed personality (blood, black bile, yellow bile, and phlegm). Friedman and Booth-Kewley note that Galen then attributed these factors not only to the development of personality, but to the development of disease as well. Such reasoning contended: excess black bile may result in a melancholic personality, leading to a depressed state and eventual physical illness. Surwit, Feinglos and Scovern (1983) note that as early as the 17<sup>th</sup> and 18<sup>th</sup> century it was observed that individuals experiencing depression or anxiety over extended periods of time were prone to developing diabetes in certain cases.

In more recent literature, the notion of emotional problems manifesting in physical presentations is presented by Balint (1955). He states, “We know that in quite a number of people, perhaps in all of us, any mental or emotional stress or strain is either accompanied by, or tantamount to, some bodily sensations” (p. 6866). Scovern (1999) asserts that patient variables, specifically emotional states and personality organizations, have direct effects upon health and treatment response. He notes that research has “demonstrated convincingly that psychological variables can alter functioning of the immune system in such a way as to increase susceptibility to infectious illness” (p. 268). For individuals suffering from illness where organic conditions are not evident Friedman and Booth-Kewley (1987) note, “when the psychological problems are eliminated, the patient is often cured” (p. 539). These assertions indicate the strong relationship between emotional functioning and health. The psychological status of the patient can not only impact relationships with others and the environment, but the health of the individual. Friedman and Booth-Kewley describe the potential for personality to directly influence physiological functioning:

[D]ependening on a person’s view of the world, typical pattern of emotional responding, and psychological resources (Kobasa, 1979), he or she would be more or less likely to experience certain physiological responses when confronted by environmental challenge. Therefore, personality would play a causal role in disease (p. 540).

In further support of such supposition, Scovern suggests that negative emotional states such as depression, stress and hostility are shown to adversely impact health, increasing susceptibility to illness such as coronary disease, infection and heart attack.

Maffei, Fossati, Rinaldi and Riva (1994) studied the relationship between androgenetic alopecia (hair loss) and diagnoses of personality disorders. They found that 76.3% (n = 89) of patients they studied suffering from androgenetic alopecia were diagnosed with at least one personality disorder, as compared with the 10.3% prevalence rate they identified in the general population. They note that the sample they studied consists only of those patients seeking medical intervention, not the general population of individuals suffering from androgenetic alopecia. Therefore, they speculate that the combination of distress brought on by androgenetic alopecia combined with maladaptive personality variables may contribute to seeking medical intervention at a higher rate than those patients who are not distressed nor suffering from a personality disorder. Specifically, the “stable pathological personality traits concerning self-image, interpersonal relationships and, consequently a fragile sense of identity, could enhance the psychic effect of hair loss facilitating psychic distress, with psychopathologic symptoms” (p. 871). Each of these traits Maffei, Fossati, Rinaldi and Riva identify are traits directly affected by personality disorders.

Dhossche and Shevitz (1999) discuss the influence a personality style or disorder may have on one’s course of treatment: “The personality characteristics of the patients will certainly affect this relationship, the delivery of health care within this context, and the outcome of medical treatment” (p. 546). Moreover, they note that personality traits and disorders may become accentuated when the individual is presented with stressful circumstances such as illness or hospitalization. Response styles associated with particular traits and disorders may become more florid as the individual attempts to cope with distress associated with illness. In fact, researchers (c.f., Rubino, Sonnino,

Pezzarossa, et. al, 1995; Maffie, Fossati, Rinaldi, et al., 1994; Gupta, Gupta & Schork, 1996 as cited in Dhossche & Shevitz, 1999) have demonstrated that personality disorders may negatively impact the presence of a medical condition. For example, Dhossche and Shevitz state that chronic dermatologic conditions “have worse outcomes in patients with predisposing personality traits” and that “Poor self-concept and obsessive traits may be risk factors for self-excoriative behavior in patients with facial acne vulgaris” (p. 553).

Friedman and Booth-Kewley (1987) further note that chronic conditions such as asthma, migraines, arthritis, ulcers and coronary heart disease afflict millions of Americans and cost billions of dollars. They suggest that, “To the extent that these diseases are ‘psychosomatic’ – that is, caused or catalyzed in part by psychological factors, -- tremendous opportunity exists for improving the health of the population” (p. 550). In their meta analysis of studies examining personality and disease relationships, they found that the “size of the relationships between personality and disease was found to be comparable to that which exists between many well-known risk factors and disease” (p. 551), concluding that “States of depression, and anger and hostility, seem to be implicated in a wide variety of diseases” (p. 552). Moreover, they claim, “Regardless of the direction of causality, there is strong evidence of a reliable association between illness and chronic psychological distress” (p. 552). Therefore, one may conclude that patients diagnosed with a personality disorder may be more prone to experiencing adverse health conditions whose cause and relief may be more related to emotional needs rather than medical intervention. The implication here being that identification of personality variables/traits/disorders and appropriate treatment may contribute significantly to alleviating illness-related complaints.

*Physician-Patient Alliance and Personality Disorder*

The establishment of a therapeutic relationship between doctor and patient may become particularly complicated when the patient has a personality disorder. Based on the misperceptions, difficulties in establishing effective communication, and tendencies to manipulate relationships inherent in individuals with personality disorders, establishing the relational parameters suggested by Stewart (1995) may be more difficult than with “normal” patients. As Nowlis (1990) states, patients with personality disorders such as Borderline Personality Disorder “are noncompliant and manipulate providers in ways that can create hard feelings among the health care team” (p. 329). Gross et al. (2002) describe these patients’ behaviors and interpersonal styles as “difficult, demanding, manipulative, noncompliant, [and] disruptive” (p. 53).

Bowman’s (1998) discussion of the occurrence of pseudoseizures further highlights the need for doctors to be able to identify personality disorders that may otherwise remain undiagnosed, thereby perpetuating a patient’s problems. Bowman defines pseudoseizures as “paroxysmal changes in behavior that resemble epileptic seizures [that are] a somatic communication of mental distress, generally in response to a psychologic conflict or other stressor” (p. 649). Bowman notes that approximately 8% to 34% of pseudoseizure patients have comorbid diagnoses of borderline personality disorder, avoidant personality disorder and histrionic personality disorder. She does not state that the personality disorder is the underlying cause of the pseudoseizure, but that it is evident that the emotional stress experienced by individuals with personality disorders who present with pseudoseizures may contribute to the manifestation of the false seizures. Most pseudoseizures are conversion disorders involving dissociative processes

or may even be the display of panic episodes, cataplexy or dissociative trance states. Their misdiagnosis, according to Bowman, results in “delay of appropriate psychological treatment, exposure to medication toxicity, unnecessary health care costs, and imposition of the stigma and lifestyle restrictions associated with epilepsy” (p. 649).

It has been suggested that physicians avoid making an Axis II diagnosis out of concern that patients will react negatively to such a diagnostic label as well as to avoid prompting their own feelings of helplessness (Emerson, Pankratz, Joos, & Smith, 1994). Noting the consequence of missing the diagnosis of a personality disorder, these researchers state that such an omission “can lead to a more difficult and frustrating treatment course for both medical and psychiatric problems” (p. 472). Moreover, they warn against persistent and fruitless efforts to identify organic etiologies where social and personality factors may indeed be the seed of the problem.

### *Personality Disorder Defined*

Personality disorders are described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*, American Psychiatric Association (APA), 1994) as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 629). While an individual may exhibit personality traits that cause periodic distress, the diagnosis of a personality disorder is made when these traits are “inflexible and maladaptive and cause significant functional impairment or subjective distress” in at least two areas including cognitions, affect, interpersonal functioning and impulse control (APA, p. 630). In distinguishing personality disorders from stress

reactions, Miller (2001) notes that personality disorders “are by definition enduring *maladaptive* patterns and should be distinguished from the exaggeration of traits that may occur in a specific context, such as the stress of medical illness” (§ 2). The *DSM-IV* notes that these impairments must be evident in long-term patterns of functioning and not just as transient personality characteristics in response to specific stressors. That is, these personality variables are the primary means by which the individual interprets and responds to the environment and, consequently, may become exacerbated in the presence of some stressor such as illness.

The specific diagnostic criteria for a personality disorder are outlined in the *DSM-IV* (1994) and include the following:

- A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:
  - (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
  - (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
  - (3) interpersonal functioning
  - (4) impulse control
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.



- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma). (p. 633)

Hahn, Thompson, Wills, Stern and Budner (1994) developed the Difficult Doctor-Patient Relationship Questionnaire (DDPRQ) as a measure for empirically identifying difficult patients. In their study, 53 physicians completed the DDPRQ along with the Practitioner Psychopathology Diagnostic Questionnaire. In researching the statistical properties of the DDPRQ, these researchers found common characteristics among those patients identified as “difficult patients” (those patients with a score of 90 or above on the measure). The researchers report that 98% of these patients elicited negative emotional responses from their physician. 90% of the patients were characterized as “demanding and irritating” and 90% of patients determined to be difficult patients on the basis of the DDPRQ scores were also identified as meeting criteria “for at least mild psychopathology” such as mood and anxiety disorders (p. 651). Moreover, the severity of psychopathology was positively correlated with DDPRQ scores. That is, the more difficult a patient was found to be (i.e., higher scores on the DDPRQ), the more severe was the level of mood or anxiety disorders. Further, 12% of the total sample met criteria for a personality disorder (established by scores on Hyler and Rieder’s (1987) Personality Diagnostic Questionnaire – Revised (PDQ-R)). While the results did not indicate a

correlation between high DDPQR scores and number of medical diagnoses, patients identified with “classically psychosomatic diagnoses” such as irritable bowel syndrome, migraines, pain and other psychosomatic symptom syndromes had higher DDPQR scores than patients not having these diagnoses.

*Effects of Personality Disorders upon Doctor-Patient Relationships*

When the “illness experience” of the patient is affected by the processes typically associated with a personality disorder (i.e., a pattern of interpersonal style and behavior that is disruptive and distressful), the capacity of the doctor (as well as other health care team members) to work with the patient, to enter into and understand the patient’s assumptive world, is challenged. If the doctor does not recognize that patient variables associated with a personality disorder are affecting the “illness experience” then that doctor is apt to encounter even greater difficulty in establishing an effective, healing relationship with the patient. As Searight (1992) notes, “encounters with [Borderline Personality Disorder] patients may be confusing and emotionally intense” (p. 605). Thus, without a knowledge and understanding of these patients’ personality dynamics, associated behaviors and interpersonal relationship patterns may be expected to be experienced as even more frustrating and unmanageable than if there was some insight into the etiology of these traits. In absence of this insight, the doctor, in reality, does not truly have an accurate understanding of the patient and the patient’s subjective “illness experience.” Following Delbanco’s thinking, the physician in this case does not know what makes the patient “tick,” thereby denying the physician of knowing how the patient’s experience affects illness, treatment, and outcome.

Pare and Rosenbluth (1999) highlight the importance of the physician-patient relationship when working with personality disordered patients: “The best overall treatment is a consistent, caring professional relationship. Physicians may feel that their role as primary care physician is a minor one in the broad scheme of the patient’s chaotic (or constricted) life, but the physician-patient relationship might be the patient’s most stable and beneficial personal association” (Clinical Management of Personality Disorder in Primary Care Section, ¶ 1)

Researchers in the medical literature (e.g., Searight, 1992; Oldham, 1994; Gross et al., 2002) note some of the characteristics typically associated with personality disorders, specifically, Borderline Personality Disorder (BPD), as encountered in medical settings. Such characteristics include impulsivity, risk for suicide, repeated self-destructive behaviors, substance use disorders and inconsistent, intense interpersonal relations. Within the primary care medical setting, patients with BPD typically present as having marked, acute depression characterized more as a mood state rather than vegetative-type depression, as having drug abuse histories, and a demanding and aggressive interpersonal style that vacillates between idealizing and devaluing doctors and staff (Searight, 1992). Moreover, patients with BPD may be expected to experience difficulty following treatment regimens and medical advice, to manipulate staff members and to, at times, be demanding and disruptive (Gross et al., 2002).

Pare and Rosenbluth (1999) underscore the difficulties encountered when working with patients with personality disorders: “Patients with personality disorders are said to be among the most difficult patients to treat in primary care medicine (Schwarcz & Halaris, 1998; Searight, 1992), because their difficult personalities make treatment of

their other medical conditions, even relatively trivial problems, more complex. These patients also tend to be emotionally disruptive and draining and can sometimes induce intense anger, deep despair, or intense boredom in their caregivers” (Clinical Management of Personality Disorder in Primary Care Section, ¶ 2).

Individuals with Antisocial Personality Disorder are considered to be difficult to treat medically due to problems in compliance with treatment regimens and problems in the areas of family, work, and social environments as well as possible alcohol and drug-related concerns (Barry, Fleming, Manwell, & Copeland, 1997). These authors note the importance of being able to identify patients with personality disorders:

Both the potential increased cost of dealing with these patients in primary care settings and the need to effectively work with patients who may be less compliant and may have multiple social and medical problems mean the primary care physicians need to understand the correlates and predictors of this disorder and to be better prepared to understand, work with, and refer patients who have personality disorders. (p. 152)

Schafer and Nowlis (1998) recognize the potential benefits of making such a diagnosis:

Although personality disorders may not be responsible for the behavior of most difficult patients, [such a diagnosis] could help the reflective clinician recognize a difficult relationship constructively, moving to potential explanations and beyond, to interdisciplinary strategies for more effective management and satisfactory outcomes. (p. 129)

Pare and Rosenbluth (1999) note that one of the primary difficulties associated with working with patients with personality disorders is their tendency to “confront the physician’s idealization of medical practice. All physicians learn over time that medicine is not as powerful and effective as originally hoped, yet no patients make this as obvious as patients with personality disorders” (summary section, ¶ 5).

The impact a personality disorder such as Borderline Personality Disorder can have upon a patient and his or her functioning in a medical setting is described by Searight (1992). He states that these patients, “may be disruptive, demanding, and noncompliant [and] often successfully provoke conflicts between physicians and their nursing staffs” (p. 605).

In short, personality disorders, such as Antisocial Personality Disorder and Borderline Personality Disorder, can create disruption within individuals and in their interactions with their environment. Relationships can be expected to be tumultuous and intense with a pattern of vacillation between idealization and devaluation of others. Their “illness experience” may be expected to be much more unpredictable and turbulent as the patients’ personality style colors this experience. Given that such patterns are evident in the “everyday” life of the personality disordered patient, the distress these individuals experience can only be expected to become exacerbated in the presence of an illness.

Bibring (1964) states that “Illness always has been understood as a stress situation, potentially traumatic and threatening to the psychologic equilibrium” (p. 75). The stress of the illness, he notes, may exacerbate a patient’s underlying psychological conflicts, conflicts that arise between defense mechanisms and the deep inner strivings of the patient. The result would be behaviors and attitudes that are driven by the conflicts

and become even more pronounced during times of stress. Given the already chaotic mood swings and/or unstable relations and unstable sense of self of patients with personality disorders, the reactions typically associated with severe illness may aggravate these patterns, highlighting the importance of an effective, potent doctor-patient relationship, although making the establishment of such a relationship much more difficult.

This, of course, is not to suggest that all disease has its roots in psychological functioning. Nonetheless, it is evident that personality factors may contribute to the identification, course and treatment of disease. As such, the importance of doctors being able to delineate personality factors, particularly those factors impacting health and upon formulating a productive, collaborative doctor-patient relationship, as well as affecting treatment adherence, is evident. If personality factors comprise some of the etiology of the manifestation of illness, then the prompt identification of those personality variables would markedly alter the course of treatment and potentially save considerable time and effort that would otherwise be misappropriated to the identification of physically-based symptoms.

*Prevalence of Personality Disorders in the Medical Setting and Rate of Diagnosis*

Primary care settings can be a gateway to mental health services. It has been reported that 50% to 60% of mental health services are provided in primary care settings (Schneidt, 2000). Nowlis (1990) states that because individuals with borderline personality disorder “often resist psychological conceptualization of their health problems, patients with BPD may be encountered more often in primary care practices than in psychological settings” (p. 329). Therefore, the primary care physician may often

be the health care professional most available to these individuals for appropriate diagnosis and intervention.

Gross et al. (2002) examined data from a survey of 218 patients from an urban primary care practice. They sought to identify the prevalence, clinical features, comorbidity, associated impairment and rate of treatment of borderline personality disorder. They found that 6.4% of patients interviewed met *DSM-IV* criteria for borderline personality disorder. They also found high rates of suicidal ideation (21.4%), psychotic symptoms (71.4%), and bipolar I disorder (21.4%) in primary care patients with borderline personality disorder. Significant social impairment was also observed in these patients. Notably though, “only about half of these patients were recognized by their primary care physicians as having an ongoing emotional or mental health problem or had received mental health treatment during the past year” (p. 57).

Dhossche and Shevits (1999) cite a prevalence rate of 7% of primary care patients having a personality disorder. They contend that this rate is comparable with the estimated 5% to 15% prevalence rate in the population. They further note that primary care patients referred to as “difficult” often presented with somatization, difficult personality styles and some type of clinical pathology such as depression and anxiety. Moreover, Dhossche and Shevits also report research suggesting that primary care physicians in a separate study **did not** recognize that difficult patients had personality disorders. That is, patients the doctors had classified as being difficult to work with were not identified as having a personality disorder that may have accounted for difficulty in developing an effective relationship.

In a study of 448 patients referred to a behavioral medicine clinic for issues such as depression, anxiety, noncompliance, difficulty with stress and adjustment to illness, Emerson, Pankratz, Joos, and Smith (1994) found that 42% met DSM-III criteria for personality disorders. In considering co-morbid Axis I diagnoses, these researchers found that 44% of those diagnosed with depression, 41% of those diagnosed with anxiety, and 46% of those diagnosed with drug/alcohol abuse also had a personality disorder. Further, there was a statistically significant higher incidence of personality disorders among those diagnosed with a somatoform disorder. However, when compared with other studies, the rate of 42% of the patients diagnosed with personality disorder is suggested to be a possible artifact of the population sampled. Specifically, the researchers suggest that the male veterans that served as the sample for this study may tend towards a higher rate of personality disorders than the general population.

In their study of 1,944 patients in primary care settings, Barry, Fleming, Manwell, and Copeland (1997) found that 8% of the men and 3.1% of the women sampled reported symptoms of Antisocial Personality Disorder. Moreover, 29.6% of the sample reported illegal drug use and there was a statistically significant rate of increased consumption of alcohol. Noting these comorbid conditions, the researchers highlight an important need for accurate diagnosis of personality disorders, “Quick, accurate identification of younger patients with ASP or conduct disorder by their primary care providers is critical if early intervention to prevent a proliferation of alcohol-related and mental health problems is to be implemented” (p. 158).

Noting that 50% to 70% of patients with some history of mental illness lasting at least one year tend to seek care from primary care physicians and that primary care



physicians “provide” almost 50% of all mental health services, Hueston, Mainous, and Schilling (1996) state that primary care physicians frequently only address patients’ physical complaints, resulting in under-diagnosis or lack of emphasis placed upon patients’ emotional and behavioral concerns and needs. These researchers note that the consequence of choosing to focus on physical issues, thereby ignoring emotional concerns that are often associated with medical complaints and can be the impetus for the utilization of medical services “raises medical costs while decreasing the opportunity for prompt and effective intervention” (p. 54).

Summarizing their review of research on the co-morbidity of chronic pain and Axis II disorders, Sansone, Whitecar, Meier, and Murry (2001) note that the prevalence rate of borderline personality disorder among patients with chronic pain varies from 0% to 15% and that “the current literature indicates that there is an association between personality disorders and chronic pain among some patients” (p. 194). These researchers’ own study focused on the prevalence of borderline personality disorder among patients treated in a residency-affiliated family medicine clinic. Seventeen male and female patients over the age of 18 who displayed any type of chronic pain were tracked over a 4-month period. Patients completed two self-report measures, Hyler and Rieder’s (1987) Personality Diagnostic Questionnaire – Revised (PDQ-R) and Sansone, Widerman and Sansone’s (1998) Self-Harm Inventory (SHI) and participated in a semi-structured interview (Diagnosing Borderline Patients (DIB), Kolb & Gunderson, 1980) in order to diagnose borderline personality disorder. In addition, participants completed the Bradford Somatic Inventory in order to identify degree of somatic preoccupation and responded to items regarding pain history and pain intensity.

Results indicated that 23.5% of participants were identified as having borderline personality disorder by one measure, 23.5% were diagnosed by two measures and 17.6% met diagnostic criteria on all three measures. The researchers note that while the presence of borderline personality disorder in their sample is 47% when using the DIB, if the sample size were increased to 50 participants with no additional positive diagnoses of borderline personality disorder, the resulting percentage of positive diagnoses would still be “unexpectedly substantial” at 16%. Results of Pearson product-moment correlations indicated statistically significant relationships between the total scores of the DIB and PDQ-R ( $r = .74$ ), the total scores of the DIB and the SHI ( $r = .67$ ), the DIB total score and somatic preoccupation total score ( $r = .55$ ) and the SHI total score and the somatic preoccupation total score ( $r = .65$ ). However, the correlation between borderline personality disorder and pain intensity was not statistically significant. Although they could not determine why this relationship was not significant, the researchers speculated that the various interpersonal and behavioral problems associated with borderline personality disorder “wash out” pain intensity. Commenting on the association between borderline personality disorder and chronic pain, the researchers state:

From a psychiatric perspective, chronic pain syndromes meld well with the dynamics of BPD including, for example, the need for frequent appointments (i.e., the attachment dynamics), role of ongoing debilitation (i.e., victim dynamics), extensive use of medications (i.e., oral self-regulation difficulties), and dependency issues. (p. 196)

*Recognizing Personality Disorders in Primary Care Settings*

Searight (1992) states, “the internal dynamics and behavior of [personality disordered] patients may interfere with the treatment of acute and chronic physical illness” (p. 612). Accounting for psychological variables, such as those associated with personality disorders, is predicated upon the physician being able to identify those variables and then having a working knowledge of how those factors become salient in establishing the doctor-patient relationship and in treatment. However, as Searight notes, personality disorders often remain undiagnosed in primary care settings.

In a recent report on oncologists’ detection of the emotional needs of cancer patients (“Cancer Patients’ Emotional Needs”, 2002), it was found that doctors may be missing signals from patients regarding their emotional functioning. In the study, the interactions of nine oncologists and 298 adult cancer patients were analyzed to identify how patients communicated informational and emotional needs and how doctors responded to these communications. It was found that patients generally gave doctors cues for informational needs twice as often as emotional needs. It was further found that doctors were effective in identifying and responding to informational needs, but failed to detect 38% of emotional cues. The results suggest that while patients may be reluctant to disclose emotional needs, “it is important for doctors to actively encourage emotional disclosure.” Without such disclosure, it was concluded that patients may have difficulty adjusting to disease. Yet, many physicians do not encourage such disclosure. Wiener and Nathanson (as cited in Sanson-Fisher & Maguire, 1980) have demonstrated that young physicians tend towards an interview style that avoids patient disclosure of emotional problems.

Bowman (1998) identifies three areas that may account for doctors' difficulties in making an accurate diagnosis. The most common problem she notes is the clinician's tendency to not consider psychological problems as the root of physiological issues. The absence of psychodynamic concepts in the medical field, she argues, prohibits reasoning that would include the possibility of psychological or emotional etiologies of these problems. Second, Bowman states that ignorance of the diagnostic existence of pseudoseizures makes it improbable that they will be diagnosed. Third are countertransference issues that prevent a doctor from making a diagnosis of pseudoseizure. She claims this would include: the physician's discomfort with making a psychiatric diagnosis over a physiological one, tendencies to believe that some patients simply can not have psychological problems, and doctors' own sense of hubris in making them believe that they are infallible in making any diagnoses.

Related to Bowman's (1998) contention that physician variables contribute to low diagnosis rates of personality disorders in the primary care setting is the Goldberg, Jenkins, Millar and Faragher (1993) study of doctors' abilities to identify psychiatric symptoms of patients using a clinical interview. They found that accurate diagnosis of psychiatric disturbance was determined by the way in which the physician conducted the interview as well as personality variables of the physicians. They also found that "doctors who can be persuaded to modify the way in which they interview their patients will be better able to make accurate ratings of minor psychiatric disorders" (p. 522). Most interestingly here, though, was their observation that "many of the doctors made an almost conscious decision not to probe for symptoms of minor psychiatric disorder, since they did not know what to do about such disorders once they had elicited them" (p. 522,

emphasis added). This point is affirmed by Anstett's (1980) observation that neophyte physicians focus on the biological factors and ignore the personal variables due to feelings of inadequacy to work with patient emotions:

[T]he strict medical model is adhered to so firmly that physicians see the diagnosing and treating of medical disease as their only responsibility. A common attitude among physicians-in-training is that it not only takes a great deal of time to explore a patient's expectations and interpretations of his problem but that this line of questioning often opens a "can of worms" that they may very likely feel incompetent to deal with. (p. 286)

Diagnosis of personality disorders, as outlined in the DSM-IV (APA, 1994) would necessitate background knowledge of a patient and his/her long-standing patterns of behavior and relationships, direct self-reporting from patients, and/or formal assessment data. However, interactions in primary care settings are not conducive to such methods of diagnosis. Physicians may not always have the history with patients to discern patterns of behavior and, most likely, lack the time or training of formal assessment. Moreover, patients are unlikely to overtly express behavior patterns associated with personality disorders.

Therefore, while the objective-descriptive criteria outlined in the DSM-IV (APA, 1994) are diagnostically useful, Miller (2001) contends that physicians must rely equally on objective and subjective information in arriving at a diagnosis: "Subjective reports and subjective impressions are inherent to physician-patient interactions and should not be discarded" (§8). In fact, Miller states that diagnostic impressions of "personality repertoires" *begin* with subjective information and that objective criteria are discerned

over a period of time. This is an especially useful tool given the relatively brief interactions doctors may have with patients in primary care settings. When objective criteria are not readily available in the course of a typical appointment, subjective data can become very important diagnostically.

Pare and Rosenbluth (1999) emphasize the importance of physician subjective self-awareness for diagnosing personality disorders in their patients:

Some patients may be intensely hostile, angry, or overly engaging in the first session and may incite an equally intense emotional response, either positive or negative, in the physician. If the physician has a very intense emotional reaction to a patient (i.e., a feeling of anger, hate, or uncharacteristically strong sympathy [with a desire to rescue the patient]) for no obvious reason, the consideration of a personality disorder diagnosis may be in order. (Clinical Management of Personality Disorder in Primary Care Section, ¶ 6)

Pare and Rosenbluth state that a physician's awareness of emotional reaction to a patient may be utilized to understand the patient as well as in formulating diagnostic opinions. Recognizing and understanding one's own emotional response to a patient can shed light upon patient personality variables. Some of the questions Pare and Rosenbluth suggest that physicians ask themselves: "Where is this feeling coming from?", "Why am I feeling this way?", "What does this feeling say (if anything) about the patient?", and "What does this feeling say (if anything) about me?" (This last question provides the doctor with a reminder that reactions are not always about patient variables, but may suggest something about her or his own self.) While this information is diagnostically useful and provides insight into the patient's dynamics, the authors warn that diagnosing a personality

disorder should still be made in keeping with DSM-IV diagnostic criteria, lest the physician risk medical and medicolegal ramifications.

Schafer and Nowlis (1998) cite research indicating that 15% to 30% of patients in primary care settings are experienced negatively by their physicians and are referred to as “difficult patients.” In their own study of 21 patients identified as difficult patients by their primary care physicians, Schafer and Nowlis found that 7 met criteria for having a personality disorder. More importantly, *none* of the primary care physicians, although recognizing them as difficult, had identified the underlying personality disorder.

*The Need for Doctors to Identify Personality Factors in Treating Patients*

Stewart (1995) notes that 50% of patients’ psychiatric and psychosocial problems are missed by doctors. Yet, once these concerns are identified, “other management options including psychiatric referral, if acceptable to the patient may be considered” (Dhossche & Shevits, 1999, p. 552). Although a referral to a psychiatrist may be appropriate, it does not alleviate the primary care physician’s responsibility for treating the patient for whatever disease or illness she or he may experience. A referral may provide a specialized setting for addressing psychiatric issues, but does not nullify the presence of these personality traits when the patient is interacting with the primary care physician. These personality patterns, by definition, are long-standing patterns and may not be expected to be extinguished simply by a referral to a psychiatrist or psychologist or other mental health provider. For whatever medical condition the patient may present, she or he still necessitates medical intervention, which will require interactions with the physician and medical staff.

Dhossche and Shevitz (1999) note that personality traits are typically assessed as a part of mental status examinations and that personality factors are important artifacts of physician observations and estimations of the patient's functioning. However, the diagnosis of a personality disorder, they note, should not be made solely on doctor-patient interactions, but on documentation of long-standing patterns of behavior and interactions resulting in significant distress for the patient. Direct questioning of functioning is not as helpful to the doctor in making a diagnosis of personality disorder as are pieces of information acquired by an understanding of the patient's patterns of interpersonal relationships and observations of behaviors.

Giron, Manjon-Arce, Puerto-Barber, Sanchez-Garcia, and Gomez-Beneyto (1998) report that most people suffering from some kind of emotional disorder are treated by primary care physicians and not psychiatrists. Yet, Giron et al. note that many patients' emotional problems are frequently not detected by their physicians and that such misdiagnosis can result in insufficient care. Those who are correctly identified, they contend, usually receive better medical treatment than those who are not correctly identified.

To ascertain what facilitates physicians' capacities to make these diagnoses, Giron et al. (1998) conducted a study of doctors' abilities to identify emotional disorders in patients using clinical interviewing skills. They found a relationship between physicians' interviewing skills and their abilities to identify emotional disorders. Those physicians who accurately identified the emotional disorder generally established eye contact with patients, spoke with them face-to-face, did not have nonconstructive verbal interruptions of patients, and asked questions with psychological content – all aspects of



effective relationships. The physicians' abilities to make accurate diagnoses were independent of their own personality factors, academic qualifications and clinical knowledge. Moreover, there was a significant inverse relationship between physicians' negative attitudes towards patients and their ability to identify emotional disorders. There was no relationship between physicians' grades in psychiatric subjects while in undergraduate medical courses nor in the time spent in continuing medical education in psychiatry and medical psychology. Thus, it would appear that physicians' abilities to accurately diagnose emotional attributes within patients is related more to their abilities to establish effective relationships with patients rather than on acquired, technical and more medically-related abilities.

Oldham (1994) states, "Not infrequently, patients with personality disorders seek help from primary care physicians for physical complaints, rather than seeking psychiatric help" (p. 1770). In fact, Oldham contends that,

When a personality disorder is present, treatment of other coexisting psychiatric or medical conditions is frequently more complicated, lengthier, or less successful, a pattern that may at times be due to lack of recognition of the personality disorder. When a personality disorder is diagnosed, more effective treatment may be prescribed, particularly in light of improved treatment strategies for these conditions. (p. 1770)

Searight (1992) states that the identification of personality disorders such as borderline personality disorder as well as a "working clinical knowledge" is essential in being able to establish a rapport with these patients in the primary care setting (p. 612). By understanding the patterns of behavior and interpersonal relations associated with

borderline personality disorder, Searight contends that the physician may become less confused, anxious and frustrated when working with these patients, thereby decreasing physician variables interfering with diagnosis of personality disorders. Moreover, by following suggestions for interactions with patients with borderline personality disorder, Searight asserts that the family physician may have “a therapeutic effect” upon the patient (p. 612). Schwenk, Marquez, Lefever, and Cohen (1989) contend that the disrupted physician-patient relationships may not only foster poor health care and patient dissatisfaction, but result in medical, social, financial, and legal difficulties for the physician as well.

Once physicians are more amenable to diagnosing personality disorders in the primary care settings, treatment of these individuals may be expected to improve. Gross et al. (2002) state that physicians’ awareness of borderline personality disorder in patients as well as a sound working knowledge of its associated features may help to provide more effective treatment of any coexisting conditions. Of specific concern they note is the associated feature of suicidal ideation common in borderline personality disorder patients. This is an important feature for physicians to have an awareness of as “up to two thirds of patients who attempt or commit suicide see their physician shortly before their attempt or death” (p. 59). Nowlis (1990) also identifies the utility in correctly identifying personality disorders such as borderline personality disorder in primary care medical settings:

In some cases, improved understanding of [borderline personality disorder] by professionals in the mental health care system has led to increased resistance to the unpleasant feelings that patients with this disorder frequently elicit in their

caregivers, more rapid and more certain diagnosis, better understanding of how and why the disorder is manifest in the patient, more realistic treatment goals, improved management strategies, and improved morale in the treatment team. (p. 329)

Muschatt, Cutler and Altman (1964) echo the importance of working with patients' emotional concerns in the successful resolution of physical complaints, "For successful treatment of many cases of physical illness, attention to the psychological needs of the patient is essential, whether it is given consciously and by design or unconsciously and intuitively" (p. 207).

In this same vein, Schafer and Nowlis (1998) note the importance of recognizing and utilizing one's own negative reaction to a patient, "Negative feelings toward patients may be 'important clinical data about the patient's psychology' (Groves, J., 1978; Smith, S., 1995) or even a 'diagnostic tool' (Goodwin, J.M., Goodwin, J.S., & Kellner, R., 1979) for recognition of underlying psychopathic disorders" (p. 126). Moreover, these researchers poignantly state, "Realistic prognosis for a difficult patient is more likely when personality disorders are detected" (p. 129). Hamilton, Decker and Rumbaut (1986) support the diagnostic utility of one's own personal reaction to patients with personality disorders, "The understandable anger evoked by the patient's manipulation is best used as a confirmation of diagnosis" (p. 198). Yet, they warn, that this information should be used diagnostically, *not* as a course for treatment. Such identification may also improve the physician's feelings of optimism in treatment, provide increased insight into feelings of patient and physician, as well as reduce the need for "unnecessary medical intervention" and its concomitant costs (p. 129). Finally, in discussing the "medicolegal

pitfalls” associated with treating patients with borderline personality disorder in medical settings, Gutheil (1985) notes, “borderline patients can mobilize intense feelings in those who treat them – intense feelings which can interfere with the use of sound clinical judgment” (p. 9).

Recognizing that a patient has a personality disorder can also provide useful information. Patients with personality disorders are often found to have other co-morbid diagnoses. In a study of 93 patients from a family practice residency training clinic, 65 were identified as high risk for a personality disorder by their responses to the Structured Clinical Interview for DSM-III Axis II (Hueston, Mainous, and Schilling, 1996). When compared to a control group, these patients expressed lower overall satisfaction with health care, including dissatisfaction in the humaneness and quality of care. However, no statistically significant differences between groups was evident for number of physician visits, use of emergency services, in hospitalization over the previous 6 months, or in daily medication use, although patients at high risk for personality disorders were more likely to be taking antidepressant medication. Further, the at-risk group was identified as having higher rates of depression and was at higher risk for alcohol dependence than the control group. Finally, patients at high risk for personality disorders tended to have lower functional status than controls.

Some of the hallmarks reported in primary care settings of patients with borderline personality disorder include: frequent phone calls to the office; requests for frequent appointments; higher rate of diagnostic procedures, sometimes for illness that cannot be found or in conjunction with requests for prescription drugs (Schneidt, 2000). Schneidt also reports some of the other warning signs in addition to high medical

utilization rates: low functional status scores, high scores on the Beck Depression Inventory, Depression comorbidity rates of 40% to 60%, and an average of two other personality disorders. Some of the reasons why patients with borderline personality disorder seek primary care services include: chronic fatigue, chronic viral infection, drug-seeking behavior, eating disorder, fibromyalgia, Hypochondriasis, medical excuse (job or lawsuit), obesity, pain, and substance abuse. Schneidt notes that the personality disorder complicates or is complicated by these medical concerns.

Hahn, Thopson, Willis, Stern and Budner (1994) state that difficult doctor-patient relationships may be associated with “mild forms of somatization, personality disorder and Axis I pathology” (p. 656) that may have been overlooked in previous studies. The more accurate clinical understanding of the difficult patient can create greater empathy from the doctor and a more informed approach to treatments and difficult patient behavior “can be compassionately understood in terms of distinct manageable components” (p. 655).

In 1978, Groves wrote a seminal article on difficult patients that appeared in *The New England Journal of Medicine* (Groves, 1978). In the article, Groves states that the presence of negative emotional reactions to difficult (or what he refers to as “hateful”) patients may manifest in various ways: feelings of helplessness in the physician; “unconscious punishment of the patient”; “self-punishment by the doctor”; inappropriate confrontation between doctor and patient; or “there may be a desperate attempt to avoid or to extrude the patient from the care-giving system” (p. 883). Obviously, none of these options is in the best interest of the physician or patient. Groves prescribes that physicians seek to identify, acknowledge and utilize the feelings evoked in them by these

patients. In fact, he states, “Negative feelings about medical and surgical patients constitute important clinical data about the patient’s psychology” (p. 887). Thus, in an effort to treat all patients the same and, in doing so, disavow her or his own emotional response to patients as distracting and/or indications of being less than perfect, the physician may actually ignore important diagnostic and prescriptive information. Groves warns:

When the patient creates in the doctor feelings that are disowned or denied, errors in diagnosis and treatment are more likely to occur. Disavowal of hateful feelings requires less effort than bearing them. But such disavowal wastes clinical data that may be helpful in treating the “hateful patient.” (p. 887).

Groves warning provides guidance for how the emotional reactions of the physician may be useful in working with difficult patients. The following recommendations from Groves contain useful suggestions for how physicians’ emotional responses to patients may be diagnostic information as well as indications of possible interventions:

[T]he doctor who begins to feel aversion toward the patient should begin to think of setting limits on dependency. The doctor who begins to feel the impulse to counterattack should begin to think of rechanneling [*sic*] entitlement into expectations of realistically good medical care. The doctor who begins to feel depressed with the patient’s smug help-rejecting should begin to think of “sharing pessimism” so that the patient’s losing the symptom is not equated with losing the doctor. And the doctor who begins to wish that the patient would die should begin to grasp the possibility that the patient wishes to die. (p. 887)

### *Training Physicians to Recognize Personality Disorders*

This study will consider the abilities of resident physicians to identify patient personality variables. Specifically, the focus will be on how residents react to patients manifesting aspects of personality disorders and how they conceptualize the physician-patient relationship when these personality styles are present. As discussed earlier, it has been demonstrated that experience alone is not necessarily an inoculation to frustration and helplessness in working with patients with personality disorders. Indeed, Smith et al. (1995) demonstrate the importance of specialized psychosocial training for residence. In their study, the effectiveness of an intensive psychosocial training program for first-year residents in internal and family practice settings was assessed. The study examines improvement in patient satisfaction based on the training the residents received in interviewing, informing patients, relationship building, personal warmth and confidence, and any areas each resident identified as an objective. The results indicate that patients experienced greater satisfaction with *trained* residents than with *untrained* residents.

Compared to other similar studies, one of the key areas Smith et al. (1995) found to be of particular potency is in the area of personal self-awareness. The researchers note that personal self-awareness “is believed by many to be a key determinant of the doctor-patient relationship and patient satisfaction” (p. 731). Thus, emphasis on improving residents’ self-awareness, which would include awareness of personal reactions to patients, may be an important training component for medical students. An awareness of patient variables (i.e., personality variables) and how one responds to such variables would seem to be an important factor in establishing and maintaining an effective working relationship with patients.

Bibring (1964) highlights the importance of training in psychiatric processes for medical students. Noting that differential diagnosis of psychiatric processes and organic disease “is of utmost significance” (p. 76), he suggests that such diagnostic efforts may be complicated when psychiatric variables may predate and are not related to the organic concerns. Emphasizing the importance of training in this ability, he writes,

The difficulties of correct diagnosis under such circumstances are admittedly great, even for the psychiatric specialist, but there is reason to believe that they will diminish as medical schools and postgraduate training centers become increasingly aware of the importance of psychiatric knowledge and incorporate it into their teaching programs. ... [Further], there is a broad, general area in medicine in which psychologic knowledge is basic and indispensable. I believe that this insight is necessary for the doctor to judge, first of all, what to tell a patient about his disease and how to inform him without traumatization but also without arousing distrust that essential information is withheld. (pp. 76 - 77)

An additional area of importance is the level of self-awareness and responsibility employed by the physician. Bibring (1964) suggests that a physician’s insight into her or his own psychological processes may be a useful tool in working with patients:

In this context the psychiatric – or, better, the medicopsychologic and medicopsychotherapeutic – approach is a most helpful tool, providing insight into the patient and into *oneself* [italics added], increasing the doctor’s skill within his own specialty by blending his medical knowledge with the understanding of the patient’s personality and psychological needs. (pp. 75 – 76)



A physician's awareness of her or his own emotional needs and inner conflicts are directly related to the capacity to relate with patients. Bibring states,

If with some patients a good and effective relation cannot be established, this is not always because the doctor does not understand the patient, but rather because he does not understand his own reaction to the patient or to the situation. (p. 84)

Bibring notes that physicians typically default to bedside manners of being understanding, warm, strong and omnipotent. While this presentation may offer patients some solace, Bibring asserts that such a standard presentation may actually serve as a defense mechanism for the physician, "It generally serves the purpose of a defensive system behind which the doctors hide whenever they are troubled or concerned over a patient or do not understand him or feel insecure" (p. 84). Typically learned between the second and fourth years of medical school, Bibring states that this mode of relating to patients is carried forward into practice without reflection. To avert this standard, non-individuated, rigid approach to patients, Bibring encourages self-reflection of how one relates with others, what personal biases and prejudices exist, and what anxieties may affect how a physician approaches different patients and situations. Bibring states,

After this has been established, the doctors, contrary to their usual tendency of maintaining that these patients simply are more difficult to handle than others, attempt now to add some self-investigation to learn why a certain type may seem more irritating or less manageable to them. (p. 85)

Muschatt, Cutler, and Altman (1964) further reflect on the physician's resistance to personal insight:

While the confrontation with physical illness unconsciously mobilizes in the physician personal concerns regarding his physical condition, the exposure to dynamic psychological concepts tends to be even more provocative for him and to threaten his defenses against self-awareness even more. (p. 219)

Bibring (1964), as stated earlier, suggests that the presence of illness and the accompanying anxiety and stress may cause personality traits to “become more marked and less manageable than under average life conditions” (p. 79). That is, over time the patient has developed various coping strategies (what Bibring refers to as personality) to maintain an equilibrium between inner strivings/impulses and defenses against the manifestations of these urges. Under the duress of illness, the patient’s equilibrium is disrupted and, in an attempt to restore that balance, the patient’s personality traits increase in intensity. However, Bibring notes that the difficulties experienced between the physician and the patient that result from the disequilibrium experienced by the patient are more readily addressed by the physician and not the patient, “One must therefore ask at this point not so much what one can request from the patient, but what one can do to help him overcome his emotional resistance so that he can accept his doctor’s recommendations” (p. 79). The implication is that the physician holds some responsibility in helping the patient address the emotional turmoil in the process of adjusting to and coping with illness. The emotional presentation of the patient cannot, therefore, be ignored, but must be identified and dealt with by both the physician and the patient, but with the physician’s lead.

That training of physicians may be an effective means towards ameliorating the negative effects of interactions with patients with personality disorders suggests that the

difficulty does not necessarily lie solely with the patient, but may also be conceptualized as a failure in the relationship between patient and physician (Anstett, 1980), with the physician shouldering some of the responsibility. Smith and Steindler (1983) note that the difficulty “may be largely a function of impaired interaction between the two individuals” (p. 107). Hahn, Thopson, Willis, Stern and Budner (1994) echo this sentiment, stating that difficulties in the doctor-patient relationship “may arise because of characteristics of the patient or characteristics of the physician” (p. 647).

These same researchers also suggest that the successful management of such patients rests not with the patient, but with the physician: physicians can “learn to change their own behavior in order to manage patients with difficult personality types” (p. 656). The prescription is to focus upon the relationship, not necessarily disease: “In short, a more appropriate focus of intervention becomes the doctor-patient interaction, and improvement in the therapeutic relationship may be a more beneficial and achievable goal” (p. 656).

### *Summary*

In summary, it is evident that personality disorders play an important role in patient healthcare. Such disorders may affect the doctor-patient relationship, course of treatment, and treatment outcome. However, it is also evident that on many occasions physicians in primary care settings do not recognize these patient variables. The result of such oversight may serve to dilute the potency of attempted medical interventions for these patients as well as frustrate the patient, doctor, and healthcare team. Thus, it is important that physicians be able to recognize these traits in patients and incorporate such

awareness into treatment approaches. A considerable part of this process relies on physician self-awareness in addition to diagnostic abilities and medical knowledge.

While there exists literature examining the prevalence of personality disorders in the primary care setting, the rate at which such disorders are diagnosed, the effects of these disorders upon illness and relationships, there appears to be an absence of research examining how physicians actually incorporate self-awareness of reactions to these patients and then conceptualize their work with these patients. In the absence of such research, a qualitative approach to examining doctors' descriptions and characterizations of how they perceive, react to, and treat patients with personality disorders is warranted.

### *Qualitative Research*

The qualitative methodology affords the opportunity to more thoroughly understand the topic being researched. Without previous similar undertakings upon which to develop hypotheses, the qualitative methodologies approach a task with the intent of discovering information rather than confirming or disconfirming the hypotheses typically associated with quantitative methods. As Hill, Thompson and Williams (1997) state, qualitative research "is especially useful in the early stages of research on previously unexplored topics" (p. 518).

Thus, with specific regard to the present topic, a qualitative, naturalistic inquiry approach provides the opportunity to develop a rich understanding of how physicians identify, conceptualize, and treat individuals with personality disorders. This research, by not making preconceived assumptions (i.e., hypotheses), begins the development of theory as the researcher enters into the assumptive and conceptual world of the physician. Together, the researcher and physician investigate, define, challenge and clarify the

process of how personality disorders are actually identified, understood, and approached by the physician in a primary care setting. Moreover, following the naturalistic inquiry approaches described by Lincoln and Guba (1985), this study will follow an emergent design. The nature of an emergent design is described at greater length in the methods section below. However, I believe it is important to understand *why* the design must be emergent rather than stagnant. Essentially, because new ground is being uncovered in this type of research, all variables cannot be known *apriori*. Thus, it is impossible to control for unknown variables. More importantly though, the unknowns and what is discovered during the course of the inquiry may be used to refine and improve the study so that an optimum level of information is uncovered. Although lengthy, I believe the following quote by Lincoln and Guba eloquently states the importance of this aspect of qualitative inquiry:

[W]ithin the naturalistic paradigm, designs must be emergent rather than preordinate: because meaning is determined by context to such a great extent; because the existence of multiple realities constrains the development of a design based on only one (the investigator's) construction; because what will be learned at a site is always dependent on the *interaction* between investigator and context, and the interaction is also not fully predictable; and because the nature of mutual shapings cannot be known until they are witnessed. All of these factors underscore the indeterminacy under which the naturalistic inquirer functions; the design must therefore be "played by ear"; it must unfold, cascade, roll, emerge. (pp. 208 – 209)

Thus, the emergent nature of naturalistic inquiry, of the proposed research here, is an essential and expected component. This allows the study to grow and change to best meet the goals and underlying concern of the research.

*Statement of the Focus of Inquiry*

This study will address how physicians work with patients with personality disorder-type characteristics and processes, specifically dependent-type and guarded/querulous-type personality styles. The focus will seek to explore how physicians identify, understand, and conceptualize patients with personality disorder-type characteristics and processes in a primary care setting. Based on a case vignette, this study examines how resident physicians actually work with personality disorder-type characteristics and processes as well as their thoughts about working with such patients in a primary care setting. The responses and reactions of resident physicians to a video-based vignette will serve as the basis for examining how the presence of personality disorder-type characteristics and processes affect interactions, relationships, and conceptualizations of the resident physicians.

*Focus of Inquiry Research Questions*

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:
  - a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.
  - b. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/querulous or paranoid type) characteristics and processes.
2. What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles?
3. What are some themes suggestive of how resident primary care physicians' characterize their reactions to patients with personality disorder-type characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles?
4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes, specifically as characterized by dependent-type and guarded/querulous-type styles, in primary care settings?

### CHAPTER III

#### METHODOLOGY

This section outlines the methodology used in the present study. This includes: the purpose of the study, a review of the use of naturalistic methods, a general description of the study, the video used for the study, key informant interviews, description of the participant sample, interview format, confidentiality, instrument, and analysis procedures.

##### *Purpose*

The purpose of this study is to develop an understanding of how the presence of personality disorder-type characteristics or processes in a patient presenting in a primary care setting affects the primary care physician's reactions to and conceptualization of the patient and their working relationship.

##### *Use of Qualitative Methods*

In order to pursue this understanding, this study utilizes primarily a "naturalistic inquiry" qualitative approach suggested by Lincoln and Guba (1985). The utility of qualitative approaches in examining areas related to health care has been extolled by other researchers (i.e., Green & Britten, 1998; Barbour, 2001; Lambert & McKevitt, 2002). Qualitative studies are useful in investigating areas of research not readily amendable to quantitative methods. Specific to the type of investigation undertaken here, Green and Britten write, "Qualitative research can investigate practitioners' and patients' attitudes, beliefs, and preferences, and the whole question of how evidence is turned into practice" (First section, ¶ 2). That is, this approach will afford the opportunity to



investigate human reactions and interactions to gain a perspective on how these areas may impact medical services.

Qualitative research may examine phenomena for which previous research does not exist. Alderson (1998) notes that within a social construction theory, relationships serve as the focus of research. Specifically, she states, “Social construction theories consider how doctors do not simply reveal realities but construct and reconstruct, for example, their patients...” (Social construction section, ¶ 3). Thus, the use of naturalistic inquiry will help provide insight into the social and diagnostic constructions (i.e., reactions and conceptualizations) of physicians working with patients with personality disorder characteristics and processes in primary care settings. As such, qualitative research examining the physician-patient relationship within a specified context may contribute to improved training and practice.

Lincoln and Guba (1985) state that the collection of data for a naturalistic study requires four essential elements: purposive sampling, inductive analysis of the data, development of grounded theory, and discussion of future steps due to the ever-emergent design of this type of research. This method of gathering and analyzing data continues iteratively until “redundancy is achieved, the theory is stabilized, and the emergent design fulfilled to the extent possible in view of time and resource constraints” (Lincoln & Guba, 1985, p. 188). That is, data is gathered and repeatedly analyzed and reanalyzed until no new information can be extracted. As such, the design of the study emerges as the study progresses so as to allow for changes to maximize information gathering and/or until available resources are exhausted.

The emergent nature of the design is indigenous to naturalistic studies such as this one. According to Lincoln and Guba (1985),

Designs must be emergent rather than preordinate: because meaning is determined by context to such a great extent; because the existence of multiple realities constrains the development of a design based on only one (the investigator's) construction; because what will be learned at a site is always dependent on the *interaction* between investigator and context, and the interaction is also not fully predictable; and because the nature of mutual shapings cannot be known until they are witnessed. (p. 208)

As such, the design of naturalistic inquiries undergoes metamorphoses as the research proceeds. The investigator must be prepared to alter the focus, methods, and interactions of the design as information is discovered. Such a process departs from conventional quantitative studies rooted in established and unchanging methodologies. Kuzel (1998) supports the notion of the emergent design, noting, "naturalistic inquiry will not start with a complete design, for to do so could impose constraints and lead to a distorted or incomplete understanding of the subject of study" (p. 666). As opposed to controlling the parameters of a research design (as in a laboratory setting), the investigator seeks to understand a phenomenon in its natural setting. To do so requires flexibility as the phenomenon may become a moving target -- changing in focus, scope, and character.

#### *General Description of the Study*

To begin to develop an understanding of how primary care physicians interact with, react to, and conceptualize patients with personality disorder-type characteristics and processes, I decided to develop a semi-structured one-on-one interview (I met with

resident primary care physicians individually) with three components. In the first component, I and a participant viewed a video of a physician and an actor-patient (who demonstrated dependent-type characteristics) discussing the actor-patient's presenting concerns (cardiac chest pain) and recommendations for further testing. In the video, we could see and hear the actor-patient (portrayed by a middle-aged Caucasian male), and could hear the physician (also a middle-aged Caucasian male). At predetermined points in the video, I would pause the video and ask the participant how she/he would respond to the actor-patient at that point. After the physician's response, I would start the video again and repeat this process until the vignette was completed. For example, at one point the actor-patient states, "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me." After the statement, I would pause the video and ask the participant, "How would you respond to that statement?" After her/his response, the video would resume and the process repeated at the next designated actor-patient statement.

The pauses in the video were selected after statements were made by the actor-patient that were demonstrative of certain personality styles characteristic of personality disorder processes. I had members of my dissertation committee view the video and provide input as to appropriate actor-patient statements that would represent good times to solicit the participant's response. Each participant was asked the same questions at the same points in the video vignette. At the conclusion of the video (approximately 8 – 10 minutes), I would ask the participant a series of questions about her/his reactions to the patient. In the second component, the same process was repeated, only, in this vignette, the actor-patient portrayed a patient with guarded/querulous type characteristics. The

third component of the semi-structured interview did not utilize the video, but involved a series of questions about the physician's thoughts about working with patients with personality disorder-type characteristics and processes. The participant was then asked for some general biographical information and the interview was then concluded. However, it should be noted that the interviews were conducted during the participants' lunch. As such, our time was limited to approximately one hour. At the end of that time, participants had to attend to patients. Indeed, there were times that residents were paged during the interview and had to make phone calls related to patient care. Because of these job-related constraints, there were times that the biographical questions could not be answered. Therefore, I would fill in the information that was evident (i.e., gender or ethnicity).

#### *The Video*

To find an appropriate video for this research, I searched video archives of the American Psychological Association, the American Psychiatric Association, the American Medical Association and other private medical and psychological education groups. However, I was not able to find an appropriate video through these channels. I then distributed an email describing my research and need for a video to a listserv for the Division of Health Psychology (a division of the American Psychological Association). I received many responses, the majority of which identified the need for a video such as I was looking, but few of which provided any suggestions. I did receive one response suggesting that I contact a physician in North Carolina, Dr. Douglas A. Drossman Professor of Medicine and Psychiatry at the University of North Carolina at Chapel Hill, School of Medicine. I contacted Dr. Drossman's office and was informed that he had

created a training video that seemed to fit my needs. I sent a check to Dr. Drossman's office and obtained a preview tape that provided samples of the actual video. I viewed the preview tape with my dissertation committee chair and we agreed that it seemed to be an appropriate video for this research. I then sent a second check to Dr. Drossman's office and obtained the complete video. The video, titled "Personality Types in Medical Care" is described in its accompanying brochure as addressing "the need for the clinician to modify his/her interview style depending on the personality of the patient." The brochure states that the actor-patient, in separate vignettes in the video, "assumes the seven classical personality types" of: dependent – overly demanding; obsessional – orderly and controlled; histrionic – dramatizing and emotionally involved; masochistic – long-suffering and self-sacrificing; paranoid – guarded and querulous; narcissistic – superior and self-centered; and schizoid – uninvolved and aloof. Through the key informant interviews (described below) and input from dissertation committee members, it was determined that the dependent and guarded/querulous types would be used for this study.

Although not explicitly stated in the video's brochure, it is evident that the seven classic personality styles represent a personality typology created by two physicians, Kahana and Bibring (1964). While Kahana and Bibring specifically state that these categories "do not designate personality disorders", but instead refer to the "psychologically normal, well-functioning person and are especially applicable to the individual in any stressful, anxiety-producing situation" (p. 108). However, for the purposes of this study, I determined that the representations of these categories were representative personality disorder-type characteristics and processes. As Kahana and

Bibring note, “Physical illness invariably represents an emotional crisis” and “psychopathological diagnosis in a given case may be warranted if there is marked accentuation of character traits, neurotic or psychotic symptoms, serious difficulty in dealing adequately with social relationships, limited capacity for work, and even impaired ability to gain satisfaction and enjoyment in life” (p. 108). The behaviors and responses of the actor-patient in the video vignettes is believed to demonstrate the “marked accentuation of character traits” sufficient to represent personality disorder-type characteristics and processes. Below I illuminate the link between the style represented in the video vignettes selected for this study and personality disorder-type characteristics and processes.

#### The Dependent-Overdemanding Personality and Personality Disorders

Kahana and Bibring (1964) describe the patient with a dependent, overdemanding personality style as needing “special attention or an unusual amount of advice ... [and] may reach out quickly and impulsively, putting himself in the hands of the doctor with an optimistic and naïve or self-assured expectation of limitless care” (p. 109). When presented with an illness, Kahana and Bibring assert that this type of patient will experience an anxiety that can result in the “wish for boundless interest and abundant care, and into a deep fear of being abandoned, helpless, and starving” (p. 110). Moreover, in an effort to reestablish a sense of equilibrium, the patient “may become extremely demanding or overdependent upon what his doctor prescribes” (p. 110). Thus, in keeping with the DSM-IV (APA, 1994) criteria of “inflexible and maladaptive” traits that “cause significant functional impairment or subjective distress” (p. 630), these characteristics described by Kahana and Bibring seem to be consistent with personality

disorder-type characteristics and processes. That is, the dependency, fear of abandonment, and overcompensation of being demanding that are characteristic of the Dependent, Overdemanding patient is representative of similar interpersonal patterns and cognitive and affective instability typically seen in individuals with personality disorders.

### The Guarded-Querulous Personality and Personality Disorders

Kahana and Bibring (1964) describe the guarded, querulous patient as “suspicious of [others’] intentions, or querulous and blameful of their motives” (p. 116). Moreover, these patients “consistently expect the worst and are oversensitive to slights and to hints of negative feelings in other people” (p. 116). The presence of illness tends to result in the patient becoming “even more fearful, guarded, suspicious, quarrelsome and controlling of others” (p. 117). Again, these traits may be representative of patterns evidenced in personality disorders. The pattern of inflexibility and maladaptive thoughts, affect and behaviors evidenced in oversensitivity to slights and efforts to control others suggest that the guarded, querulous nature of these individuals may represent personality disorder-type characteristics and processes.

An important distinction for the diagnosis of personality disorder is that the characteristics and processes are long-standing patterns and are not the result of medical illness or stress associated with medical illness. In the vignette, the physician is not aware as to whether or not the exhibited traits are long-standing, medically-related, or responses to stress. As such, the possibility of a personality disorder can not be ruled-out at that time and should be taken into consideration as a possible reason for the manifestation of behaviors evidenced in the vignette. In fact, Miller (2001) draws upon the Kahana and Bibring (1964) nosology in his article that discusses an expanded version

of personality types described by Kahana and Bibring that “coincide roughly with DSM-IV Axis II personality disorders” (§ 10). Thus, this effort here to utilize Kahana and Bibring personality types to represent characteristics and processes of personality disorders is not unique and without precedent.

### *Key Informant Interviews*

Given the emergent nature of naturalistic inquiry (Lincoln & Guba, 1985), I decided to pursue interviews with key informants to assist in learning about the culture of medicine and to refine the original design of the study and the interview questions. According to Lincoln and Guba, informants can provide “an ‘inside’ view of the norms, attitudes, constructions, processes, and culture that characterize the local setting” (p. 258). Moreover, “Such information is especially useful to the inquirer who has not been able to practice prior ethnography [such as myself], but who needs to be immersed in the local context as thoroughly and quickly as possible” (p. 258). As such, I sought out primary care physicians and members of my dissertation committee for assistance with the design of and interview questions for the study.

After receiving the videotape, I reviewed the vignettes with one of the dissertation committee members, a psychiatrist who practices in the primary care setting where data were ultimately gathered. Together we selected two vignettes that seemed to best capture characteristics and processes of a personality disorder (the Dependent-Overdemanding type and the Guarded-Querulous type). We then reviewed a set of possible interview questions and made some changes.

I then met with two primary care physicians from a local private hospital. In each interview, we reviewed the selected vignettes, discussed their own reactions to the actor-



patient, discussed the culture of primary care practices, expectations of resident primary care physicians (from whom data were gathered), and refined interview questions. The first interview provided some verification that the vignettes in the video provided an accurate depiction of some patients in primary care settings, stating that the video is “not too out of bounds.” The second primary care physician interviewed also provided helpful feedback, especially in interview question design. He suggested developing a sense of immediacy in the interview by asking the participants, “When the patient said ..., how would you respond to the patient?” He also recommended beginning with broad questions following the video in order to obtain physicians’ impressions of the actor-patient. Specifically, he suggested first asking questions such as, “How did you feel about this patient?” Both of these informants discussed the culture of residents in primary care settings. Each noted that residents will encounter “difficult” patients, but also stated that they most likely will not have received prior training in how to work with these patients.

After these interviews, I met with two other dissertation committee members (each a licensed psychologist). I met with one of the members in person to review the video and interview questions. His primary suggestion was to increase the sense of immediacy in the interview by pausing the video at designated places and asking the participant to respond to the actor-patient instead of waiting until the end of the vignette to repeat actor-patient statements and ask for responses at that time. The other member viewed the video by himself and provided verbal feedback on interview questions. He supported the ideas of asking for participant responses during the course of the video and of beginning with broader questions regarding impressions and reactions to the actor-patients after each vignette.

Once this process was completed and a final set of interview questions designed, I again met with my dissertation committee chair for a final review of the design. After receiving his approval, I proceeded with the participant interviews. Finally, after the first four participant interviews, I met with the committee member who is a psychiatrist to review some of the responses and determine if any changes to the protocol were needed. The only change that was decided upon at this point was for me to be more persistent in asking participants for responses to one of the questions. It was noticed that participants tended not to respond to the intent of one of the questions. As such, it was decided that I should be more direct in asking the participants to specifically address what was being sought in the question.

### *Participants*

Within a qualitative design, sampling differs considerably from that of a quantitative design. The general goal of sampling in a quantitative design is to obtain a representative pool of participants with the hopes of being able to generalize, not to other samples, but to other settings. Because the qualitative study is rooted within a specified context and the goal is depth of understanding of a specific phenomenon, “the purpose of sampling will most often be to include as much information as possible, in all of its various ramifications and constructions” (Lincoln & Guba, 1985, p. 201). These authors further note, “The object of the game is not to focus on the similarities [of the sample] that can be developed into generalizations, but to detail the many specifics that give the context its unique flavor” (p. 201). Moreover, the goal of the purposive sampling in a qualitative design is to access sufficient information upon which the emergent nature of the design may unfold and the substance of the grounded theory may be based.

Given the different types of sampling outlined by Patton (1980), Lincoln and Guba (1985) recommend the use of maximum variation sampling. This type of sampling allows the investigator to document uniqueness among participants within a given context by examining the breadth (variation) of experiences of participants. It is this uniqueness that provides the details germane to the focus of the study, the richness and depth of information to allow for maximum understanding. Again, because the objective is not similarities for the purpose of generalization, but to understand by having knowledge of the range of behavior, thoughts, feelings, and biases of the interviewees allows for a more comprehensive picture of physician-patient relationships and the subtle nuances affecting those relationships and treatment.

With regards to sample size, Lincoln and Guba (1985) state, “In purposeful sampling, the size of the sample is determined by informational considerations. If the purpose is to maximize information, then sampling is terminated when no new information is forthcoming from newly sampled units; thus *redundancy* is the primary criterion” (p. 202). Although Lincoln and Guba (1985) note that sampling may halt once redundancy of information is achieved (i.e., the same patterns and themes begin to emerge in successive interviews and no new information is available), I decided to interview the entire sample available. This sample consisted of 15 resident Family Medicine physicians from the Texas A&M University Health Science Center College of Medicine. I determined that because the sample was readily available and the logistics of accessing each potential participant were relatively easy, it was worth the effort to secure all interviews available. Moreover, as themes would be repeated, successive interviews

allowed for more in depth discussions of those themes, potentially revealing more detailed information.

Participants consisted of 15 Family Medicine (i.e., primary care) resident physicians from the Texas A&M University Health Science Center College of Medicine who were participating in the Family Practice Residency of the Brazos Valley. The residency program is located in Bryan, Texas, serves the Brazos Valley area, and provides both inpatient and outpatient care to a ethnically and social-economically diverse clientele. The residency program is divided into 3 years. Each year contains 6 residents. Three of the residents were not able to participate. One resident left the residency for employment before he could be interviewed. A second resident left on maternity leave before she could be interviewed. Finally, a convenient day and time for an interview could not be found for a third resident.

One of the committee members for this dissertation is a faculty member in the College of Medicine with the Texas A&M University Health Science Center. He also serves as a psychiatrist in the Family Practice Residency of the Brazos Valley. He graciously utilized his contacts within the residency program to enlist the support of the program for participation. After speaking with the department head of the program and securing his approval, the committee member arranged for me to be able to have contact with the residents. I then contacted the coordinator of the residents' schedules and set times to meet with each resident individually. Prior to meeting with the residents, they each received an overview of the study, assurances that their participation or non-participation would have no bearing on their evaluations as residents, and that participation was strictly voluntary.

*Interview Format*

Interviews were held at the Family Medicine Residency program location. Interviews were conducted either in an office or small conference room and included only myself and the interviewee. Since interviews were conducted during the residents' lunch, I provided lunch for them. The room consisted of a table and chairs, television and video cassette recorder (for viewing the video), and an audio cassette recorder to record the interviews. In addition to recording the interviews, I kept notes of the interviews during the course of the interview.

At the beginning of each interview, I again explained that participation was strictly voluntary and that participation and the information gathered through the interview had no bearing on the resident's grading or status with the Family Medicine Residency program or the College of Medicine. Consent and confidentiality were explained (including the release of relevant resident information detailed in the *Instrument* section) and the resident and myself then signed a consent form. A separate copy of the consent was then provided to the participant. A general description of the study was then provided prior to beginning the interview. The tape recording was then begun and the interview started. Prior to beginning the video vignette, the participant received a written version of the vignette. It included basic relevant information about the patient in the vignette and presenting complaints. The first vignette was shown, during which the video was paused at predetermined points to solicit a response from the participant. At the end of the first vignette, the resident was asked questions about her/his responses and reactions. The same format was then followed for the second

vignette. Following the second vignette, a series of more general questions were then asked about working with patients with personality disorders in primary care settings.

Interviews lasted approximately 60 minutes. At the end of the interview questions, I then asked the residents for some basic biographical information, asked if they had any questions, and then concluded the interview. At the conclusion of each interview, I briefly reviewed my notes and clarified any short-hand notations made. Written notes kept during the course of the interview included direct quotes of the participant, paraphrases of responses, and any additional notations about the response and/or participant. The night of each interview was then spent transcribing the audio recording of the interview. The transcriptions also contained direct quotes, paraphrases, any additional notations (such as decisions to add additional questions as perceived necessary as the interview unfolded). Transcriptions were then printed and filed the following day.

### *Confidentiality*

This study has received approval of the Texas A&M University Institutional Review Board. As noted above, each participant was informed of both the voluntary and confidential nature of participation on multiple occasions. Both the participant and myself signed the informed consent form prior to the beginning of the interview and a copy was provided to the participant. Confidentiality was insured by using a coded number for each participant. Only the original signed consent form has both the name of the participant and her/his number. The hand-written notes taken during the interviews and the transcriptions of the interviews utilize the coded number. Moreover, any direct quotations used in this dissertation and any subsequent publications will also utilize the

coded number. Any information reviewed by dissertation committee members will also only utilize the coded numbers.

### *Instrument*

Due to the emergent nature of a qualitative study, the human-as-instrument is the best suited means for data acquisition, because, as Lincoln and Guba (1985) affirm, “*only the human instrument has the characteristics necessary to cope with an indeterminate situation*” (p. 193). Kuzel (1998) notes the distinction between quantitative (or rationalistic) paradigms and qualitative (or naturalistic paradigms), stating that rationalistic approaches utilize the method of investigation (i.e., rigor and inflexibility in design) to control for error. However, within the naturalistic paradigm, error is not the focus, but breadth and depth of understanding are (which may involve the embracement and investigation of anomaly rather than controlling for and excluding it). Because the naturalistic grounded theory approach seeks to understand new ground, the focus is not on testing hypotheses, but the “purpose is the discovery of hypotheses” (p. 666). This ability to cope with indeterminacy is characterized by Lincoln and Guba in 7 qualities of the human instrument: responsiveness, adaptability, holistic emphasis, knowledge base expansion, processual immediacy, opportunities for clarification and summarization, and opportunity to explore atypical or idiosyncratic responses.

Kuzel (1998) notes that the focus of naturalistic research is in understanding a culture. He quotes J.P. Spradley’s comment that “Rather than studying people, ethnography [or naturalistic inquiry] means learning from people” (p. 665). Thus, the use of interviews allows the investigator to tap into and strive to understand the world/culture of the participants, to understand their thoughts, beliefs, paradigms, emotions, language,

values and other such variables that flavor and guide their existence in that culture. Moreover, Kuzel proclaims naturalistic inquiry's suitability to the study of medicine, specifically, family medicine:

As I have argued earlier, naturalistic inquiry's stress on context and understanding from the viewpoint of the subjects of study are consistent with family medicine's espoused attention to the individual within his or her environment and concern for understanding the patient's perspectives on health and illness as appropriate to the discipline of family medicine ... I believe our understanding of behavioral sciences is rudimentary, and our application of what little is known is limited and awkward. Naturalistic inquiry could inform this basic science of family medicine and thereby inform the health care its practitioners deliver. (p. 669).

Although Kuzel's comments address understanding patient experiences and perspectives, those of the practitioner are of equal importance (particularly given the role of the physician-patient relationship so fundamental to treatment and progress discussed earlier). Through understanding the culture and experience of the physicians and, subsequently, areas of further investigation and training, health care is indeed better informed and, hopefully, patient care may be affected.

Kuzel (1998) quotes other researchers who have championed the use of qualitative methodologies in family medicine research:

Strict operationalizations of the classic research paradigm present two limitations when transposed into family medicine research: 1) restriction of the content of the investigation and reduced likelihood of discovering



unexpected outcomes that may be judged very useful, and 2) increased realization that there is very little room for unattached theorizing and speculating. (p. 668)

Kuzel summarizes the arguments of several researchers:

To summarize these authors, family medicine [primary care] research would do well to include a paradigm that may be applied in the arena of clinical practice, that recognizes the importance of context, that takes account of multiple levels of organization – individual, family, community – and that allows for the emergence of understanding as part of the inquiry process. These characteristics will help make family medicine research “appropriate to the discipline.” The basic themes of concern for the individual, attention to context, and a melding of science and humanism will underpin both the specialty and its research. (p. 668)

In short, qualitative methodologies are not only an appropriate research approach for primary care studies, but are in keeping with the traditions of primary care medicine: focus on context, understanding of the individual, and application of science to the human condition.

#### *Analysis – Overview of Constant-Comparative Methodology*

Naturalistic qualitative research methods were used to analyze the data collected. Due to the apparent absence of studies examining how physicians in primary care settings recognize, react to and utilize the presence of personality disorder-type characteristics and processes in relating to and treating patients in primary care settings, this study sought to identify themes and patterns of the physicians’ responses and reactions to such

patients. In doing so, an initial step may be taken in developing an understanding of how personality disorders affect doctor-patient relationships and treatment. Moreover, because the interviews consisted of resident physicians in a primary care setting, these results may be useful in illuminating areas for further training for residents that may better serve them in working with these types of patients.

Qualitative research seeks to achieve this end by “understanding the complexity of people’s lives by examining individual perspectives in context” (Heppner, Kivlighan, & Wampold, 1999, p. 235). By using a constructivist paradigm of qualitative research approaches to discern an understanding of individuals’ representations of the world, this methodology does not rely on testing hypotheses, but strives to interpret and reinterpret data to ascribe meaning to events and actions, “to understand the social constructions of the participants” (Heppner, Kivlighan, & Wampold, 1999, p. 244).

This study has striven to develop a theory regarding physician-patient relationships in a primary care setting when the patient presents with personality disorder-type characteristics and processes. Because this study is not based on any previous theory of such interactions, there have been no a priori hypotheses upon which to make comparisons. The theory under development here is based on the data that has emerged from the study. As such, this study follows a grounded theory approach originally coined by Glaser and Strauss (1967). Glaser and Strauss define grounded theory as a theory that will:

[F]it the situation being researched, and work when put into use. By “fit” we mean that the categories [in which theory is grounded] must be readily (not forcibly) applicable to and indicated by the data under study; by

“work” we mean that they must be meaningfully relevant to and be able to explain the behavior under study. (p. 3)

Within the grounded theory approach, data analysis followed a method initially described by Glaser and Strauss (1967) as constant comparative method. The data analysis here followed this methodology as later refined by Lincoln and Guba (1985). According to Lincoln and Guba, data are referred to as *constructions* produced by the data sources (i.e., the interviewees) and the data analysis is the *reconstruction* of that data. Lincoln and Guba summarize this process in the following,

The process of data analysis, then, is essentially a synthetic one, in which the constructions that have emerged (been shaped by) inquirer-source interactions are reconstructed into meaningful wholes. Data analysis is thus not a matter of data *reduction*, as is frequently claimed, but of *induction*. (p. 333)

Indeed, Lincoln and Guba (1985) note that naturalistic data analysis follows four dimensions originally defined by Goetz and LeCompte (1981). These dimensions are identified as: inductive-generative-constructive-subjective (as opposed to the dimensions of deductive-verifactory-enumerative-objective typically associated with more conventional quantitative approaches). This is to say that naturalistic data analysis is: derived from the data itself (inductive) as opposed to being defined apriori by hypotheses; an attempt to discover constructs/themes/patterns (generative); an abstraction of units of analysis from the data (constructive); and a reconstruction of the participants' own experiences (subjective) rather than an objective approach of applying pre-existing notions to data.

The specific type of qualitative analysis used in this research is a constant comparative analysis. Lincoln and Guba (1985) assert that the constant comparative method of data analysis strives to meet the aforementioned dimensions of naturalistic analysis suggested by Goetz and LeCompte (1981). Moreover, these researchers note that this method provides a nice fit with the emergent nature of the naturalistic paradigm whereby there is a simultaneous process of collection and analysis of data. That is, as data are collected and analyzed, the information learned from preliminary analysis help determine the scope and focus of subsequent data collection. As outlined briefly below, combining the original steps outlined by Glaser and Strauss (1967) with the refinements of Lincoln and Guba (1985) there are five major parts of the constant comparative method of analysis: (1) unitizing; (2) categorizing; (3) integrating categories and their properties; (4) delimiting the theory; and (5) writing the theory.

Once an interview occurred, I processed the data in a series of steps. As noted above, the primary source of data analysis were notes taken during and immediately following each interview and transcripts of each interview. These notes and transcripts serve as the basis for **unitizing** the data into individual units. Units are the independent pieces of data gathered from the interviews. Each unit (which may be represented by a sentence, part of a sentence, or even a paragraph) must have two characteristics defined by Lincoln and Guba (1985). First, each unit should be a heuristic piece of information in that it serves as an understanding the investigator needs or an action the investigator needs to take. Second, each unit should be the smallest piece of information able to stand on its own. That is, be it a sentence, fragment or paragraph, the unit should in itself “be interpretable in the absence of any additional information other than a broad

understanding of the context in which the inquiry is carried out” (Lincoln & Guba, 1985, p. 345). Each unit is entered onto its own index card. The unit is written on the front of the card, while the reverse side contains coded information pertinent to that unit (i.e., respondent information or location of the information such as interview number and paragraph number).

Once the units are created, the process of **categorizing** the units begins. As outlined by Lincoln and Guba (1985), categorizing seeks to identify provisional categories in which units have some commonality. The first card is examined, its contents noted, and placed in its own initial group. The second card is then examined and a determination is made on the “look-alikeness” or “feel-alikeness” (i.e., constant comparison of a subsequent card to previous cards) test identified by Lincoln and Guba as to whether or not its contents are the same as the first card. If so, it is placed with that card. If not, it is placed in its own initial grouping. The same process is carried out with the next and some subsequent cards. Cards that do not seem to fit a previous category nor seem to justify the creation of a new category are placed in a miscellaneous pile to be reviewed later.

Once categories have accumulated 6 to 8 cards per category, an attempt is made to make provisional statements about the cards in each category that seem to relate to the same content. These statements constitute the properties of a category which then contribute to the development of a rule for inclusion within the category. Once the rules are defined for the categories, the units within each category are examined to determine if they meet the rule of the respective category. This may result in revision of the rule, discarding cards into the miscellaneous set, or development of subcategories. Once

categories have established rules, subsequent attempts to place a card in a category are no longer made on the “look-alike” or “feel-alike” basis initially used, but is based on the rule itself. This again may lead to category and rule revisions and/or additions of new categories and subcategories. Here the inductive nature of this type of analysis is readily apparent. As more information emerges, the theory that begins to take shape may be modified. No pre-existing or *a priori* framework dictates the analysis of the data; the data drives the analysis and, hence, theory development -- *inductively*.

Once all available cards are reviewed, the category sets are reviewed as the integrating categories and their properties process unfolds. Attention is first given to cards in the miscellaneous pile. Attempts are made to place cards into categories or cards may be found to be entirely irrelevant and may be discarded. Others may remain uncategorizable and are kept separate. However, Lincoln and Guba (1985) note that the percent of cards that are not placed into categories should not exceed 5 to 7 percent of the total number of cards. Overlap between categories is analyzed. It may be found that further category revisions are necessary and/or that some cards are inappropriately prepared (i.e., too much information included in a unit which needs to be divided into further units). The rule of thumb offered by Lincoln and Guba states, “Categorization can be accomplished most cleanly when the categories are defined in such a way that they are internally as homogeneous as possible and externally as heterogeneous as possible” (p. 349). Relationships between categories are also identified which may result in subcategorization, creation of new categories, and/or identification of categories that logically should exist but have yet to be identified. This review may help in identifying the focus of subsequent interviews. As identified by Lincoln and Guba, the subsequent

interviews may help in further delineating the existing categories and those that may yet be defined. This may be done via “extension” (extending the base of information already gathered), “bridging” (identifying and understanding the connection between seemingly related pieces of information), and/or “surfacing” (identification and follow-up of new categories “because the logic of the situation ‘demands’ them” (Lincoln & Guba, 1985, p. 350).

According to Lincoln and Guba (1985), data collection and processing of data may cease when one of four criteria are met. First, there is “exhaustion of sources” whereby available sources have all been interviewed. Second, collection and processing may stop with “saturation of categories.” This occurs when further data and analysis do not add new information. “Emergence of regularities” is the third criteria. This may occur when there appears to be a sophisticated level of complete integration of data gathered. Finally, data collection and processing may stop at “overextension.” This is defined as only finding new information unrelated or distantly related to the initial scope of the investigation; the new information, although unrelated to previous categories, does not contribute to a unique understanding the initial problem being explored (or relevant and important areas that have emerged during the course of the investigation).

Delimiting the theory then begins as parsimony and scope take shape in the formulation of the data. This generally may begin to occur towards the end of data collection when unique information is no longer evident. Moreover, delimiting may occur as improvements in articulation (i.e., rule definition) and integration of categories proceeds. This is to say that as data collection is completed, the categories that have emerged from the identified units become well defined (i.e., clear rules for inclusion),

saturated (i.e., no new information is uncovered), and heterogeneous (i.e., there is no discernable overlap between categories). At this point, writing the theory may commence (which will be done in the Results and Discussion sections).

### *Analysis – Establishing Trustworthiness*

Within conventional quantitative analyses, researchers typically address the trustworthiness of data and results through the following: internal validity; external validity; reliability; and, objectivity. The naturalistic approach essentially uses four analogues to each of these areas in establishing trustworthiness claims related to analyses. Lincoln and Guba (1985) identify the following criteria: credibility (truth value of data and results); transferability (applicability of results to other contexts); dependability (consistency of information); and, confirmability (neutrality). Below I provide brief descriptions of each, suggested means of meeting each criteria proposed by Lincoln and Guba, and a discussion of how those criteria are met in this study.

According to Lincoln and Guba (1985), the credibility (or truth value) of a study is demonstrated when I, as the investigator, have “*represented those multiple constructions* [of the interviewees] *adequately*, that is, that the *reconstructions* [of information supplied by interviewees] ... are *credible to the constructors of the original multiple realities*” (p. 296). One of the primary methods Lincoln and Guba recommend for establishing credibility is through the use of member checks. As Kuzel (1998) notes, “for the naturalist, reality is not universal and everywhere the same; rather, it is defined by the source of the data – the group of people understudy” (p. 667). As such, members from whom the original data are gathered may be asked to verify that the information is accurate. This may be done informally (i.e., through immediate verification) and



formally (i.e., using “knowledgeable individuals” to review results and constructions. Informal member checks were conducted during the course of the interviews themselves. Instead of just asking the questions on the interview form, I strove for clarification of interviewee comments through question, reflection, and interpretation followed by request for verification from the interviewee. Moreover, at the end of each interview, I asked the interviewee if “there is any other information that was not covered that seems important.” This question provided the interviewee with an opportunity to provide any additional information he or she may deem important for me to obtain a clear understanding of his or her perspective. A formal member check was sought through one of the dissertation committee members. He is a psychiatrist practicing in the Family Practice Residency of the Brazos Valley where the participants also practice. In his role, he consults with the residents and provides didactic training as well. As such, he is very familiar with the setting and context within which the residents practice and upon which much of their information is drawn for the interviews. The formal member check consisted of Dr. DeVaul reviewing the results of the study, providing suggestions in regards to the identified categories and themes, and validating the appropriateness of the findings.

Second, within conventional studies, the researcher strives for external validity or generalizability, the degree to which results may be applied to other groups. The naturalistic analogue, not subscribing to a single reality, does not focus on generalizability of results to other settings, but rather the transferability of findings. That is, based on the similarity of contexts between the study and other settings, findings from the study may transfer to another context. This is determined, according to Kuzel (1998),

by the extent of fit between the contexts, which “can only be judged if one has a great deal of information about the setting that was studied” (p. 667). This statement highlights the need for the detailed, thick descriptions offered by naturalistic inquiries. The thick description serves as the basis for determining the extent to which findings may be transferred to other contexts. As Lincoln and Guba (1985) state, “the responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgments possible” (p. 298). It is then the responsibility of subsequent researchers who intend to identify the transferability of this study to theirs to determine if the contexts are similar enough to warrant such comparisons:

Thus the naturalist cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility. (Lincoln & Guba, 1985, p. 316)

Lincoln and Guba note that the definition of what constitutes “thick description” is relatively undefined. However, they note that in general, thick description may consist of two things: first, a thorough description of the context and setting of the investigation; and, second, a thorough description of the processes relevant to the study observed in that context. This thick description is provided throughout the study: from the discussion of participants used, the instrumentation used, description of the video, and discussion of how the interviews were conducted.

Next, quantitative researchers’ concern for consistency in instrumentation (reliability) results in instrumental inconsistencies being treated as error (Kuzel, 1998). However, within naturalistic inquiry, given that the investigator is the instrument,

inconsistency is expected. Moreover, the emergent nature of the study creates a moving and changing target, necessitating inconsistency in instrumentation – the investigator must shift as the focus of the study changes with new information. Thus, there is no one reality, no one fixed target; the naturalistic investigator, according to Kuzel, is aware that the reality is instability. Yet, the study still needs some marker of dependability (the analog of reliability for qualitative researchers).

Dependability may be demonstrated by an audit trail (Lincoln & Guba, 1985). It is established by “taking into account both factors of instability and factors of phenomenal or design induced change” (p. 299). The audit trail provides a detailed documentation of the sources of data and the process of the study and interpretations. This may be established through thorough record keeping that would allow an auditor to trace a piece of data from its categorical placing back to its original source. The audit trail also provides readers with an understanding of how the study evolved and how and why the focus shifted and, consequently, how and why the investigator shifted. Given the logical progression of the study based upon the data as it emerged from the study provides the basis of the dependability (i.e., reliability) of the findings. This may be established through the use of record keeping that charts the progress of the study along with notations about changes in design and reasons for changes. For example, in the methods section I have discussed how information from key informants helped to shape the design of the study.

Finally, Kuzel (1998) notes that traditional quantitative methodologies seek objectivity in the findings. That is, quantitative methods attempt to reduce the amount of investigator bias and obtain a more objective measure of the subject of study.

Naturalistic approaches, however, accept the role of investigator in the processing of data. However, to ensure that the values and biases of the investigator do not themselves obscure the data, naturalistic investigation strives for confirmability of findings. As Lincoln and Guba (1985) state, “The issue is no longer the investigator’s characteristics but the characteristics of the data: Are they or are they not confirmable?” (p. 300).

As with dependability, confirmability may be established through an auditing process (Lincoln & Guba, 1985). There must first exist a clear audit trail. These include the following: raw data (i.e., recordings and interview notes); data reduction (transcripts of interviews); data reconstruction (i.e., derived categories); process notes (i.e., how study was carried out); materials (i.e., articles and notes contributing the study); and, instrument development (i.e., forms used in the study and schedule of appointments). Each of these areas is confirmed by the auditor and addressed in the auditor’s letter attesting to their existence (Appendix C).

The second part of confirmability is established via the audit process (Lincoln & Guba, 1985). This process involves an auditor familiar with the material that is the focus of the study reviewing materials associated with the study, data, and findings and determining if they provide sufficient basis for the verifiability of conclusions. Lincoln and Guba credit Halpern (1983) with the establishment of a defined auditing process. Essentially, this process consists of 5 steps that move from the contractual agreement about the parameters of the audit between the researcher and auditor, to a determination of the trustworthiness of the results, and, finally to closure through feedback and writing of the letter of attestation. Lincoln and Guba provide a detailed explanation of these steps, but it is important to note two critical aspects in determining trustworthiness here.

First, the auditor determines the confirmability by establishing that the results of the study are indeed grounded in the data collected. Second, the dependability of the results are verified through the establishment of a well-reasoned, thorough, and transparent emergent design and analysis. Again, these areas are addressed by the auditor in the letter of attestation (Appendix C).

#### *Changes in the Focus of the Study*

As the study unfolded, I found it necessary to change the original research questions (Focus of Inquiry Research Questions in naturalistic nomenclature) I had outlined. After my original proposal was submitted, I continued to add more to the literature base and began to refine the design of the study. During this process I began to realize that the original questions did not seem to best address the underlying concern of the study: how to do primary care physicians work with patients with personality disorders? Moreover, as the actual interviews were conducted, my concerns about the questions seemed to be confirmed.

While changes in design and research questions are avoided in quantitative methodologies, they are anticipated in qualitative research. Lincoln and Guba (1985) refer to research questions as the “focus of the inquiry.” They note that a change in focus is, as opposed to quantitative research, an expected aspect of naturalistic inquiry:

[T]he focus of the inquiry can and probably will change. Conventional inquirers regard such changes as absolutely destructive of their inquiry designs (“you will confound the variances hopelessly”); the naturalist expects such changes and anticipates that the emergent design will be colored by them. Far from being destructive, they are constructive, for these changes signal movement to a more

sophisticated and insightful level of inquiry. Thus the naturalist begins with a particular focus in mind (however tenuous) but has no qualms about altering that focus as new information makes it relevant to do so. (p. 229)

Thus, the focus of the inquiry presented in the Statement of the Focus of the Inquiry reflect an improved understanding of what is being studied informed by continued review of literature and shaped by the emergent design of the study itself. I believe that these foci afford a better opportunity to develop a sense of how physicians work with patients with personality disorder-type processes and characteristics.

#### *How the Analyses Unfolded*

The analyses that I undertook very closely mirror the format outlined by Lincoln and Guba (1985). Unitization of the data was determined to consist of residents' entire responses to each question. I felt that doing so would ensure that I could best capture the essence of a resident's response style. Breaking a resident's response to a question into smaller pieces could have fragmented the nature of the response by separating pieces of information and would not have provided an accurate representation of the perspectives of the resident.

The categorization process deviated slightly from the recommended format. Given that each question contained at most a sample of 15 given that there were 15 residents who participated (and some questions had fewer than 15 when some questions were omitted for individual interviews due to time constraints or some questions added to the interview later were not asked of earlier participants), category sizes were relatively small. As such, the recommendation that 6 to 8 units of data be gathered before assigning a definition to the category was replaced. Units of data were categorized by the same

look alike approach outlined by Lincoln and Guba (1985). However, a category definition was not determined until all units for a specific question were sorted. At that time, data units for an apparent category were reviewed and a categorical definition was identified. Then each unit was compared to that definition and was determined to continue to be included or was excluded based on fit with that definition. Those units that no longer fit were compared to definitions of other categories for possible inclusion or were separated into new categories as needed.

I continued this same process for three iterations of the analysis. That is, after the initial sorting of units into categories and identification of category definitions, I returned to each category and again compared data units to the category definition to determine appropriateness of fit. At times, I would compare a unit of data for one category to the definition for another category to insure heterogeneity of the categories. I then completed the process one more time.

Finally, the auditor reviewed the category definition and the units in that category to determine goodness of fit for approximately 75% of the data. The purpose of this audit was two-fold. First, it was important to determine whether or not the categories and definitions were rooted in the actual data and not based on some preconception that I may have had. Second, as a physician, the auditor was able to assess the relevance of categories to the field of medicine. During the course of his audit of the analysis, where necessary, units were added or removed based on his review of the information. Before any change was made the auditor and I discussed the possible reasons to and not to move the unit and reached a consensus before any change was made.

Other than these modifications, the remainder of the analysis mirrored the framework provided by Lincoln and Guba (1985).

*Audit of the Analysis*

The auditor followed the auditing recommendations of Lincoln and Guba (1985). In all, approximately 75% of the data was audited to establish trustworthiness. The auditor concluded that the analyses and results met the requirements of the audit and certified the results (see Appendix C for a copy of the letter of attestation the auditor completed).



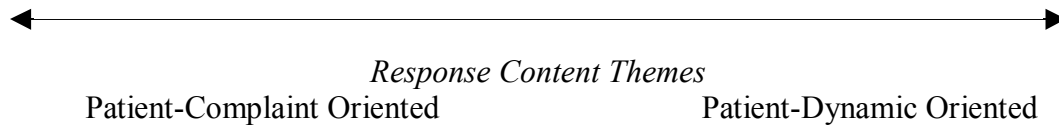
## CHAPTER IV

### RESULTS

The findings presented in this chapter are the results of the data analysis. The analysis sought to meet the intention of the research, including analyzing the raw data collected during semi-structured interviews for categories and themes suggestive of how primary care resident physicians work with patients with personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles.

#### *Overview of the Levels of Analysis and Interpretation*

The results of the data analysis are reviewed by presenting the themes and respective categories that emerged in reference to each focus of inquiry. Two broad themes emerged from the categorization of the data: resident responses that primarily tend to focus on the physical concerns of the patient and/or tend to be more solution-focused and boundary setting and responses that at a minimum touch upon the patient's emotional concerns / personality dynamics and tend to be more collaborative and engaging. I refer to the first theme set of responses as "Physician-Complaint Oriented" and to the second theme set of responses as "Patient-Dynamic Oriented." Figure 1 presents this dichotomy – which will be presented within a larger framework of response styles in Chapter V.



*Figure 1.* Continuum of Response Themes: Complaint vs. Dynamic.

This dichotomy of themes will serve as the basis upon which to review the categories of the data in this chapter. While the results are presented in this dichotomous format, this is not to say that the data might not be considered in a different manner. As a reflection of life, there is a continuum of response styles that exists within and between these two distinct styles. However, for the purpose of this study, it is most useful and heuristic to work within a more dichotomous format. As such, I have chosen a more basic interpretation of the data. There are more fine-grained interpretations that may be derived. Perhaps even more reflective of the diversity of life experiences, this range of possible interpretations could differ from person to person reviewing the data. Through the use of an auditor who is a physician familiar with the content and context of this study, I was able to find some support for how I interpreted these data. Through our discussions, we agreed that a basic interpretive scheme would provide a more understandable means of applying these findings to medical education and practice. In Chapter V, I suggest propositions for understanding possible motivations behind these dichotomous response styles as well as their possible effects upon the doctor-patient relationship. This suggested framework will also be presented in a more dichotomous manner.

### *How the Results Are Presented*

The results of naturalistic inquiry are the categories of the data and the themes found among the categories. A suggested theory or framework for understanding those themes may then be suggested. Thus, the framework arises out of, or is grounded in the data itself – hence the idea of grounded theory discussed by Lincoln and Guba (1985). To present the results, I introduce the themes and categories for each Focus of Inquiry Research Question separately and provide examples of those response categories. Again, for each Focus of Inquiry Research Question, responses to different questions from the interview (including questions asked in response to the actor-patient in the video vignettes and questions asked after the video vignettes) are used. For Focus of Inquiry Research Questions utilizing the video vignettes, participant responses are used for both the first vignette (dependent-type) and the second vignette (guarded/querulous-type). Further, for each set of responses to a given interview question, responses are sorted into categories. It is from these categories that the basic dichotomous themes emerged. Please see Appendix D for a list of the Focus of Research Inquiry Question and the interview questions used to address that research question. The following general format is followed for each Focus of Inquiry Research Question:

1. Statement of the Focus of Inquiry Research Question.
2. The heading for the theme to which subsequent categories belong (e.g., either “Patient-Complaint Oriented Response” or “Patient-Dynamic Oriented Response”). When a theme is presented within a Focus of Inquiry Research Question that utilizes the video vignette, the personality style portrayed in the vignette is provided – either Dependent-Type or Guarded/Querulous-Type.

3. The prompt from the interview to which the residents responded. In some instances, the prompt is a statement made by the patient in the vignette. In other instances, the prompt is an interview question I asked the resident. See Appendix A for basic interview format, Appendix B for a list of questions added during the course of the study and in keeping with the emergent design. The parenthetical at the end of the prompt represents the vignette (i.e., V1 = first vignette (dependent type)) and the prompt used (Q1 = first quotation). More than one prompt may be used per Focus of Inquiry Research Question.
4. The respective category/categories for each prompt, including example(s) of each category. The title of the category indicates the relevant criteria/rule that the data unit must meet to be part of that category. Italics are used to delineate the resident's responses. At the end of the resident's response is the resident's identification number in parentheses along with the vignette and question number (i.e., 002R, V1Q1 represents resident 002's response to first vignette (dependent type)) and the first quotation). Bracketed information in the responses represents questions/thoughts I shared during the resident's response. These are often clarifying statements/questions that are the essential member checks required for establishing trustworthiness of the data and analyses.

The specific format for each question will be provided at the beginning of the section answering that question.

Appendices O through AC contain each category for each Focus of Inquiry Research Question and the respective responses for each category.

The outline format for presenting the results for Focus of Inquiry Research Question 1 is:

## **I. FOCUS OF INQUIRY RESEARCH QUESTION 1**

### **A. FOCUS OF INQUIRY RESEARCH QUESTION 1A**

#### **1. PATIENT-COMPLAINT ORIENTED THEME – DEPENDENT-TYPE VIGNETTE**

##### ***a. First Prompt***

1a. Categories from the Prompt and Example(s)

##### ***b. Second Prompt***

1b. Categories from the Prompt and Example(s)

##### ***c. Third Prompt***

1c. Categories from the Prompt and Example(s)

#### **2. PATIENT-DYNAMIC ORIENTED THEME – DEPENDENT-TYPE VIGNETTE**

##### ***a. First Prompt***

2a. Categories from the Prompt and Example(s)

##### ***b. Second Prompt***

2b. Categories from the Prompt and Example(s)

##### ***c. Third Prompt***

2c. Categories from the Prompt and Example(s)

### **B. FOCUS OF INQUIRY RESEARCH QUESTION 1B**

#### **1. PATIENT-COMPLAINT ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE**

##### ***a. First Prompt***

1a. Categories from the Prompt and Example(s)

##### ***b. Second Prompt***

1b. Categories from the Prompt and Example(s)

**c. *Third Prompt***

1c. Categories from the Prompt and Example(s)

2. PATIENT-DYNAMIC ORIENTED THEME – GUARDED/QUERULOUS-TYPE  
VIGNETTE

**a. *First Prompt***

2a. Categories from the Prompt and Example(s)

**b. *Second Prompt***

2b. Categories from the Prompt and Example(s)

**c. *Third Prompt***

2c. Categories from the Prompt and Example(s)

**FOCUS OF INQUIRY RESEARCH QUESTION 1**

FOCUS OF INQUIRY RESEARCH QUESTION 1A

What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by: Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

PATIENT-COMPLAINT ORIENTED THEME – DEPENDENT-TYPE VIGNETTE

***First Prompt: “I know I’m going to be ok with you taking care of me.***

***I’m just so relieved because nobody in my family would believe me.” (V1Q1)***

Categories from the Prompt and Example(s)

1. Resident deals only with the physical symptoms.

*He definitely has a problem. I need to validate to him that he has some kind of problem. I need to “stratify his risk factors” for heart disease. I want to explain to him that the next step is a stress test and then look for any other problems that may be present [speaking of physical problems here]. (V1Q1, 002R)*

2. Resident identifies confusion and anxiety of the patient and tries to clarify a plan of action.

*I’m kind of concerned that he is anxious. I think at this point I would probably reiterate that we don’t have a diagnosis and that his symptoms are atypical and that there isn’t a definitive diagnosis and try to kind of alleve [sic, as in alleviate] his anxiety. (V1Q1, 006R)*

**Second Prompt: “You’ll be there when I have this won’t you?” (V1Q2)**

Categories from the Prompt and Example(s)

1. The goal of the response is to “educate the patient” to reduce his anxiety.

*I think the patient has some element of ignorance as far as the test is concerned. Like I said initially, I would educate the patient. First of all, I would reiterate that he is high risk because of the fact that he has a lot of risk factors that predispose him to heart problems. Secondly, I would kind of be more general ... I mean, usually, I would give him a pamphlet to read and understand what a stress test is and seek some more information and then tell him that I am going to schedule it.*

*I would just not dive into it. People generally get scared, patients especially, if they are not informed. And, I think he still needs some information to make an informed decision. I think that process is lacking. The physician just dives in by saying, “I am going to rule-out that you don’t have heart problems, but I am going to schedule this test to check your heart.” I think that is fine, but I think he needs to go a little more into depth as far as the stress test and educate the patient. I think patient education is vital. That allays a lot of anxiety and prepares the patient. I think that the preparation is not there (in the video). (011R, V1Q2)*

2. The resident indicates that he/she will not be there, but will consult with the physician who will help.

*Usually, this is a test done by the cardiologist and the cardiologist is the one that is present at the stress test and there is a nurse there. And, if there are any questions that you may have at that time, they’ll be happy to answer them. This is something that they*

*do on a regular basis, they have experience in this. If you have any questions about it before hand, I'll be glad to explain it to you. (014R, V1Q2)*

3. The resident indicates that she/he will try her/his best to be there.

*Depending on how the office is set up, if I was capable of being there, certainly I would. (008R, V1Q2)*

***Third Prompt: "So I can call you at any time?" (V1Q3)***

Categories from the Prompt and Example(s)

1. Resident indicates that the patient may call the clinic/answering service to get in touch with her/him.

*I would tell him that a doctor is on-call 24 hours a day as with this clinic [Brazos Valley Residency Clinic]. (002R, V1Q3)*

2. Resident states that it is ok to call and tries to educate the patient.

*Here again, it is all a matter of patient education. The doctor (in the video) gives the false sense of reassurance to the patient that "you can call me anytime". Now, if the patient is undergoing a stress test and during the process of the test, he begins to undergo any changes, the doctor should tell him that, "You are going to be monitored throughout the test and you are going to have people there who are trained to look after you as part of the process and you'll have a cardiologist who does the test." So, I think issues of informing the patient are lacking (in the video) and preparing the patient and the patient is not well educated. (011R, V1Q3)*

PATIENT-DYNAMIC ORIENTED THEME – DEPENDENT-TYPE VIGNETTE

***First Prompt: "I know I'm going to be ok with you taking care of me.***

***I'm just so relieved because nobody in my family would believe me." (V1Q1)***

Categories from the Prompt and Example(s)

1. Resident gets more background information – especially why the family did not believe the patient.

*I would ask him, "How long has it been going on?" Obviously he has had told people about this before. Obviously in the past, his family at least hasn't believed him. Now, why would they not believe him? I would be thinking that as well. Has been faking other illnesses in the past? I (the patient) am glad you're believing me as opposed to others*



*who have not believed me in the past. Investigate that [this statement by the patient] a little bit more. (005R, V1Q1)*

***Second Prompt: “You’ll be there when I have this won’t you?” (V1Q2)***

Categories from the Prompt and Example(s)

1. The resident indicates that she/he will try her/his best to be there and acknowledges patient’s anxiousness/dependent style.

*It is a different circumstance because I do these tests and yes, I would be there, because I would be doing the tests. However, my response to him if I were sending him to a cardiologist would be, “I won’t be there that day, but I’ll see you soon thereafter.” He’s obviously worried, obviously anxious about the outcome of the test. (010R, V1Q2)*

***Third Prompt: “So I can call you at any time?” (V1Q3)***

Categories from the Prompt and Example(s)

There were no resident responses that fit a category for this prompt that fit the theme of patient-dynamic oriented.

**FOCUS OF INQUIRY RESEARCH QUESTION 1B**

What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by: Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (Guarded/Querulous-Type) characteristics and processes.

**PATIENT-COMPLAINT ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE**

***First Prompt: “Three hundred and fifty more dollars. And if that test doesn’t work?***

***Then what? Another test? And then another test?” (V2Q1)***

Categories from the Prompt and Example(s)

1. The resident places the responsibility for treatment on the patient.

*I would tell him that there are certain standards of care that I must adhere to. There is an “algorithm” that must be followed within that standard of care that dictates procedures to follow. I am obligated to do certain things. I would let him know that it is his prerogative to do the test or not; he has a choice in whether or not to do the test. [When asked, she explained that the choice is that she as a doctor can only suggest tests. As a part of empowering the patient, he has the choice of taking the test or not taking the test.] She also noted that she would tell him that if the tests are negative, this may help provide some reassurance to him that there may not be anything significantly wrong with him. (002R, V2Q1)*

2. The resident states that the tests are medically necessary – educating the patient.

*He is a little bit aggressive. It seems like he does not trust. I wouldn’t say antisocial, but he is getting there. [Question: What would you say to this statement?] It is very important, that we need to find out if your heart is functioning, to have the test screen in order to find out if your heart is ok, so we can treat. This is a question of medical necessity; it is not a luxury. (003R, V2Q1)*

3. The resident emphasizes dealing with monetary concerns of the patient.

*I would say, “What you’re coming here for is not uncommon as far as chest pain. There is a certain way we go about evaluating that. I would advise you that you have this stress test done. Based on those results, we’ll make the next step. You certainly don’t have to take my advice. It’s going to be your responsibility as how far you want to take this. If money is an issue, there are ways that we can help pay for this. We can certainly set you up with a social worker and see if there is any financial aid that you can get. I don’t think the money issue should be the most important reason that we do or do not do this test.” (004R, V2Q1)*

***Second Prompt: “Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?” (V2Q2)***

#### Categories from the Prompt and Example(s)

1. The resident is putting the responsibility for treatment on the patient.

*You could try and explain to him that if everyone with chest pain went straight to the cardiologist, they would be working 24 hours a day and still couldn’t see everybody. I don’t think in this case that would be the best response to him. Again, you could just say, “It doesn’t matter what you should have done or shouldn’t have done, the point is that right now my recommendation is that you get this stress test done and this is how we need to go about doing it.” (004R, V2Q2)*

2. The resident explains the clinic’s procedure for seeing patients.

*The walk-in clinic is where we screen out all the sick people to send to the cardiologist because the cardiologist is unable to see everybody out there, he can only see the sick patient and our job is to see which one is the appropriate patient to send to the cardiologist, to the specialist. (003, V2Q2)*

3. The resident confronts the patient.

*I would definitely say, "Either you are going to calm down and listen to me or you can go see another physician." (012R, V2Q2)*

***Third Prompt: "If you people don't like patients, then why do you let patients even come here?" (V2Q4)***

Categories from the Prompt and Example(s)

1. The resident apologizes to the patient and explains the system.

*I would just apologize and tell him that I am very sorry. Tell him that maybe I saw a very sick patient before him or something else that may have been the reason for running late. Explain the system and that I understand he is having to pay for parking and the doctor's visit, but we are trying to do our best to take care of him. (013R, V2Q4)*

2. The resident does not apologize and states that the patient has a choice to leave or to stay.

*I would say, "You are a little bit going over your limit. Let's just stop right here and end this conversation. These are my recommendations." Because, you are doomed whether you say something or not. I would just stop it right there and probably leave the room. (012R, V2Q4)*

PATIENT-DYNAMIC ORIENTED RESPONSE THEME - GUARDED/QUERULOUS-TYPE

VIGNETTE

***First Prompt: "Three hundred and fifty more dollars. And if that test doesn't work?***

***Then what? Another test? And then another test?" (V2Q1)***

Categories from the Prompt and Example(s)

1. The resident directly addresses the patient's apparent emotional reaction.

*I need to know what your situation is. Whether this is your heart or not. Or else, I honestly cannot treat you. Then, try to figure out what it is that he is most worried about.*

*Is he asking this out of a context of being broke or out of a context of being upset by something? I would try to find out what the source of his upset is. (010R, V2Q1)*

***Second Prompt: “Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?” (V2Q2)***

Categories from the Prompt and Example(s)

1. The resident acknowledges the patient’s emotions and tries to work with the patient.

*He’s (the patient) drawing the doctor (in the video) in. His (the doctor’s) voice just came up and he tried to jump in and got defensive. That is a game I don’t think you can play with, especially this kind of personality. He’s already irritated and angry, frustrated -- understandably, we are giving him tests that are negative for a pain that he feels. It’s hard not to do; it is hard not to strike back and get defensive whenever somebody is attacking you, saying that you’re ordering these tests and conspiring against them. So, I think you have to be real careful. As far as what I would tell him is again, reassure him that we are all working for him and that, while medicine is not perfect, we do the best we can. (015R, V2Q2)*

***Third Prompt: “If you people don’t like patients, then why do you let patients even come here?” (V2Q4)***

Categories from the Prompt and Example(s)

There were no resident responses that fit a category for this prompt that fit the theme of patient-dynamic oriented. However, for the third prompt, there was a category that appeared neutral (i.e., neither complaint-oriented or dynamic-oriented). The category is: “Resident lets the patient vent anger and listens.” An example would be participant 009R’s response to vignette 2, question 4, “What made you comment on that?”

*Summary of Results of Focus of Inquiry Research Question 1*

Given these categories of responses to vignette-based questions, the participants in this study appear to demonstrate two basic interaction themes that describe how they interact with patients with personality disorder-type characteristics and processes, specifically dependent-type and guarded/querulous-type. Themes were identified based on the content of responses residents provided when asked how they would respond to the actor-patient in the video vignette.

One theme suggests a tendency to focus on patient physical complaints and identifying solutions and setting boundaries with the patient. A second theme indicates an inclination to identify and potentially address the possible underlying psychological variables that manifested in the behavior and interaction style demonstrated by the actor-patient. While these themes are presented as two distinct styles, it is likely that there exist a continuum of response styles that contain varying degrees of these two primary themes and, perhaps in many cases, a mixture of both.

The outline format for the presentation of results for Focus of Inquiry Research  
Question #2 is:

## **I. FOCUS OF INQUIRY RESEARCH QUESTION 2**

### **A. PATIENT-COMPLAINT ORIENTED THEME**

#### **1. PATIENT-COMPLAINT ORIENTED THEME – DEPENDENT-TYPE VIGNETTE**

##### ***a. First Prompt***

1a. Categories from the Prompt and Example(s)

#### **2. PATIENT-COMPLAINT ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE**

##### ***a. First Prompt***

2a. Categories from the Prompt and Example(s)

#### **3. PATIENT-COMPLAINT ORIENTED RESPONSE THEME – GENERAL QUESTIONS**

##### ***a. First Prompt***

3a. Categories from the Prompt and Example(s)

##### ***b. Second Prompt***

3b. Categories from the Prompt and Example(s)

### **B. PATIENT-DYNAMIC ORIENTED THEME**

#### **1. PATIENT-DYNAMIC ORIENTED THEME – DEPENDENT-TYPE VIGNETTE**

##### ***a. First Prompt***

1a. Categories from the Prompt and Example(s)

#### **2. PATIENT-DYNAMIC ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE**

***a. First Prompt***

2a. Categories from the Prompt and Example(s)

3. PATIENT-DYNAMIC ORIENTED RESPONSE THEME – GENERAL  
QUESTIONS

***a. First Prompt***

3a. Categories from the Prompt and Example(s)

***b. Second Prompt***

3b. Categories from the Prompt and Example(s)

**FOCUS OF INQUIRY RESEARCH QUESTION 2**

What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

The themes for this Focus of Inquiry Research Question will utilize the same dichotomous themes of patient-complaint oriented and patient-dynamic oriented themes.

PATIENT-COMPLAINT ORIENTED THEME

PATIENT-COMPLAINT ORIENTED THEME FOR DEPENDENT-TYPE VIGNETTE

***First Prompt: What would you do to establish a working relationship  
with this patient? (V1Q1)***

Categories from the Prompt and Example(s)

1. The resident focuses on setting boundaries and referring. There may be some mention of building rapport.

*Start with the next goal of information outlined for the patient. “Sit right here, I am going to get my nurse on the phone and we’re going to get everything scheduled for you so you know where and when to be before you leave this office.” I would call the patient sooner if results necessitated that call or if medication is needed. If the patient has any questions or concerns, he can call the office and leave a message and “within a few hours or a day I can get back to you.” 001R agreed that there would need to be a lot of clarification and understanding. (001R, V1Q10)*

#### PATIENT-COMPLAINT ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE

***First Prompt: What would you do to establish a working relationship  
with this patient? (V2Q10)***

#### Categories from the Prompt and Example(s)

1. The resident is not sure how to work with the patient or chooses to address finances only.

*I would try to, like I said, you never know, I’ve had some patients like that. They start off like that and end up to be some of the nicest people, they are just having a bad day. If they continue to act like that, then I would tell him that he needs to find another physician because obviously he doesn’t feel confident enough that we are providing the care that he came looking for.*

*[Question: If his anger continues like that, what do you think is driving that anger? What is behind it, what is the point of that? If his complaint is not valid, but this is just the way he is, what do you think the anger is about?] He either has severe financial stress and he’s just not directing it in the right direction or he has no respect for the opinion of the doctor or the expert physician role. (008R, V2Q10)*

#### PATIENT-COMPLAINT ORIENTED THEME – GENERAL QUESTIONS

***First Prompt: What kind of qualities do you think a primary care physician would need  
to work with somebody who has a personality disorder? (GQE1)***

This question was added towards the end of data collection as it became apparent that such a question could accentuate the information being collected. As such, only six participants responded to the question. Five of the responses fit into the first category



style of being more patient-complaint focused and one of the responses demonstrates a more Patient-Dynamic oriented response.

#### Categories from the Prompt and Example(s)

1. The resident stated a need to be patient, understanding and setting boundaries.

*They need to be professional. They need to understand the disorder, to understand the need for boundaries. To not get offended, to be thick skinned. To not play into their personality type: if they try to bait you, then you don't bite. (015R, GQE1)*

***Second Prompt: When you realize that you have a patient with a personality disorder, does that change how you conceptualize the patient and treatment? (GQE2)***

#### Categories from the Prompt and Example(s)

1. The resident would change how she/he communicates.

*First of all, I think there is a little problem with the psychological labeling. I don't think anybody is one category. They are usually a combination of ... Although, it is true, some people certainly have a tendency to be self-centered and unfeeling with their statements, etcetera. I guess, if I did feel that this person did have that predisposition and they are already labeled as such, I don't think it would affect my medical decision making, but it would probably affect the way I decide how to approach them. In what way, I am really not sure. I wish I could give you a direct answer. I am really not sure.*

*Most people come to you because they are looking to solve a problem. I think with someone like that, you have to sort of define the rules possibly. I think with someone like that you have to say, "Look, you're here for this and this." As you slowly build a rapport with them, I think you need to say, "You know, this is what you are here for today. We'll see how we can solve this." I we'll see if he decides to continue to come back.*

*So, I don't think it would affect my medical decision making, but I certainly talk differently to a grandmother than to a kid. So, I think with someone like that, you have to be much more didactic. I think you have to set up rules at the beginning of the encounter as to what you will do in this encounter and what they can expect so that there is no misunderstanding. (006R, GQE2)*

The responses in this category do indicate an awareness that people are different and that people with a personality disorder may require a different way of communicating that would be useful in dealing with personality styles. However, the content of the

residents' responses suggests a lack of understanding of how to effectively facilitate that communication, especially when compared to the Patient-Dynamic response category.

#### PATIENT-DYNAMIC ORIENTED THEME

##### PATIENT-DYNAMIC ORIENTED THEME – DEPENDENT-TYPE VIGNETTE

***First Prompt: What would you do to establish a working relationship  
with this patient? (GQE1)***

##### Categories from the Prompt and Example(s)

1. The resident would engage the patient with things such as more frequent visits.

*I would see him more often. A lot more often than a normal patient. He needs the reassurances, so I would definitely schedule to see him more often than other patients.*

*[Question: Within those visits is there something you would do differently, a style you would take on that would be different?]*

*I would be more open to him and try to take down his guard, try to gain his trust. Right now he does not seem to trust anybody.*

*[Question: Are there certain things you would say to get him to take down that guard? What would that look like?]*

*I guess I could tell him that I need to see him more often so that we can develop a good, trusting relationship and if we can develop a good physician-patient relationship, then it would be good for both him and me. (003R, V1Q10)*

##### PATIENT-DYNAMIC ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE

***First Prompt: What would you do to establish a working relationship  
with this patient? (GQE1)***

##### Categories from the Prompt and Example(s)

1. The resident is willing to work with the patient and engage him. Interventions range from: boundary setting; seeing the patient more frequently; validating the patient; establishing trust; and helping the patient understand the process.

*Follow-up. Make sure I do follow-up with him. If I do tests, after the tests get the results back to him. Have the results on the table for the next time I see him. Call him after the test and tell him he's fine or if he's not fine, set up an appointment and we'll make it sooner if we have to. Calling is very important to keep that rapport open, especially if it is a difficult patient. Keep communication open. Once you do something [wrong], they go somewhere else, they go to another doctor and find one that can help them. But, if you show that you are caring and you call them, their responsive and they respect that and they come back to see you. (005R, V2Q10)*

#### PATIENT-DYNAMIC ORIENTED THEME – GENERAL QUESTIONS

***First Prompt: What would you do to establish a working relationship with this patient? (GQE1)***

##### Categories from the Prompt and Example(s)

1. The resident suggests patients, insight into personality disorders, and self-awareness.

*Interest in these patients. Patience. Insight into personality dynamics. Self-awareness. Awareness of how one is reacting when with a patient. [Referring to an earlier response when he noted that an awareness of his own emotional reaction to a patient can help him gauge how he is responding so that he does not respond out of anger, anxiety or defensiveness.] (010R, GQE1)*

***Second Prompt: When you realize that you have a patient with a personality disorder, does that change how you conceptualize the patient and treatment?(GQE2)***

##### Categories from the Prompt and Example(s)

1. The resident would question the patient's physical complaints and suspect some alternative non-physical reason for the physical complaints.

*Well, yes and no. More so kind of how you are going to interact with them. I am not sure how to word it. I guess if patient A comes in and you have been seeing her for a number of years and you know her not to have a personality disorder and she comes up with a new complaint, you are might take that just at face value. Whereas patient B has some histrionic features and they come up with a new symptom or something that is starting to bug them, I think in the back of your mind you're not as apt to take them at face value. Whether that is good or bad depends on the situation.*

*[Question: Not taking them at face value because...?] Not taking them at face value because in the back of your mind you know this person has a personality disorder. Depending on the disorder they have, maybe they are making it up or it is not that bad or ... I don't know. I am talking in real generalities here.*

*[Question: Something else might be going on here than what the actual complaint is?] Right. Some other kind of psychological or psychiatric problem might be going on. (004R, GQE2)*

### *Summary of Results of Focus of Inquiry Research Question 2*

The themes that emerged in reference to this question are also presented in a dichotomous manner, with the understanding that a range of styles most likely exists. For explanatory and heuristic purposes, a more basic interpretation is warranted.

The themes demonstrated here seem to suggest that the participants in this study have two distinct styles for establishing a relationship with a patient demonstrating personality disorder-type characteristics and processes specifically manifesting as dependency or guardedness/querulousness. One approach suggests a more distancing and paternalistic style. This theme is termed "Patient-Complaint Oriented" and may be characterized as providing responses to the patient which keep the patient and physician apart and may interfere with a more collaborative relationship. This effect will be expanded on in Chapter V. This may be done by establishing firm, rigid boundaries, maintaining an authoritarian presentation, or being generally ambivalent about working with the patient instead of the potential disease. The responses also suggest a tendency to work with other concerns such as finances. There may be some mention of needing to establish a relationship with the patient, but no discussion of how this would happen.

The second approach indicates a more approaching/collegial style. In this manner, the physician seems to seek to establish a working relationship with the patient

by engaging the patient not just on the physical complaint level, but on emotional and psychological variables as well. This theme is also Patient-Dynamic Oriented, indicating the resident's openness to addressing the dynamic nature of the individual and not just the disease or other superficial concerns. The effect may be a more approaching and engaging way of working with patients. Thus, physicians in this study established doctor-patient relationships at a more superficial level by addressing complaints or established a relationship based on understanding and engaging the patient's personality dynamics.

The outline format for the presentation of results for Focus of Inquiry Research Question #3 is:

### **I. FOCUS OF INQUIRY RESEARCH QUESTION 3**

A. Paragraph explaining the themes that emerged

B. PATIENT-ONLY REACTION ORIENTED THEME

1. PATIENT-ONLY REACTION ORIENTED THEME – DEPENDENT-TYPE

VIGNETTE

**a. *First Prompt***

1a. Categories from the Prompt and Example(s)

**b. *Second Prompt***

1b. Categories from the Prompt and Example(s)

2. PATIENT-ONLY REACTION ORIENTED THEME –

GUARDED/QUERULOUS-TYPE VIGNETTE

**a. *First Prompt***

2a. Categories from the Prompt and Example(s)

**b. *Second Prompt***

2b. Categories from the Prompt and Example(s)

**C. SELF-AWARENESS REACTION ORIENTED THEME**

**1. SELF-AWARENESS REACTION ORIENTED THEME – DEPENDENT-TYPE**

**VIGNETTE**

**a. *First Prompt***

1a. Categories from the Prompt and Example(s)

**b. *Second Prompt***

1b. Categories from the Prompt and Example(s)

**2. SELF-AWARENESS REACTION ORIENTED THEME –**

**GUARDED/QUERULOUS-TYPE VIGNETTE**

**a. *First Prompt***

2a. Categories from the Prompt and Example(s)

**b. *Second Prompt***

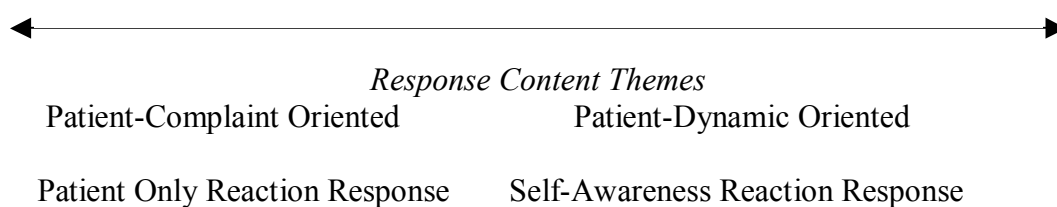
2b. Categories from the Prompt and Example(s)

**FOCUS OF INQUIRY RESEARCH QUESTION 3**

What are some themes suggestive of how resident primary care physicians characterize their reactions to patients with personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

The response themes suggest that residents were either patient-oriented in their responses or patient-oriented *and* demonstrated a level of self-awareness of how they

react to patients. Given that the literature has indicated that self-awareness is a useful tool for understanding patient dynamics and responding effectively to patients (e.g., Groves, 1978), self-awareness served as the delineating factor in categorizing responses for this focus of inquiry research question. The thematic dichotomy that became apparent is categorized as either expressing a personal reaction to the patient (Self-Awareness Reaction Response) in addition to acknowledging aspects of the patient, or only identifying characteristics of the patient in response to the question (Patient-Only Reaction Response). The Self-Awareness Reaction Response is in keeping with Patient-Dynamic Response categories because, as prescribed by Groves, such awareness may enhance an understanding of patient dynamics and needs. The Patient-Only Reaction Response is in keeping with the Patient-Complaint Response categories in that a greater depth of understanding the patient is lost when an individual ignores subjective reactions. (see Figure 2)



*Figure 2.* Continuum of Response Themes: Patient-Only Reaction vs. Self-Awareness Reaction.

PATIENT-ONLY REACTION ORIENTED THEME

PATIENT-ONLY REACTION ORIENTED THEME – DEPENDENT-TYPE VIGNETTE

***First Prompt: What is your overall reaction to this patient?(V1Q6)***

Categories from the Prompt and Example(s)

1. The resident identifies Patient-Dynamics (i.e., anxiety), but not his/her own reaction to the patient.

*He is a difficult patient. He is a dependent and anxious patient. He seems like somebody with a lot of underlying psychiatric issues. I don't want to discount the chest pain, but there seems to be something else going on with the anxiety. 002R stated that she may try to address the physical and psychiatric issues at the same time. She would address the psychiatric concerns by trying to identify why he is worried. For example, she would inquire as to whether someone he knows or a family member recently had similar medical problems and that this may be the cause of his anxiety. (002R, V1Q6)*

***Second Prompt: What kind of feelings did this patient evoke in you? (V1Q7)***

Categories from the Prompt and Example(s)

1. The resident indicates no stated emotional reaction to the patient.

*"What do you mean by emotional response?" Did I feel sorry for the guy? [There is a whole range: mad, happy, sad, feel sorry for him. Did anything come up for you?] No. (007R, V1Q7)*

PATIENT-ONLY REACTION ORIENTED THEME – GUARDED/QUERULOUS-TYPE VIGNETTE

***First Prompt: What is your overall reaction to this patient?(V2Q6)***

Categories from the Prompt and Example(s)

1. The resident states what her/his reaction is NOT.

*From my standpoint, this is something I guess we expect sometimes with patients, especially when you are warning them of something that could be dangerous or which can have a dangerous impact on their lives. Patients generally tend to be frustrated and there is some element of denial initially, that is one of the first responses to disease or illness.*

*Reaction-wise, if you ask me my personal reaction, it would just be, I would just stay calm. I would not overreact. I would not be angered. I would not be frustrated from a clinician standpoint that here I am trying to aid the patient, trying to determine the cause of his problems and the patient is kind of ungrateful. I would not be involved with all of those feelings. (011R, V2Q6)*



2. The resident's reaction is solely about the patient: 1) Figuring out Patient-Dynamics and working with those; or, 2) Identifies patient problems, but not determine how to work with those.

*1) He's frustrated and I understand that. If he's been sitting there for a while and had to pay \$10 to get into the parking garage, I understand that these folks are human just like anybody else and can snap when placed under pressure. And this guy just seems to be a very ... probably has a controlling personality, tries to stay on-top of things and is feeling a little bit frustrated and helpless: "You're not able to fix it" and is lashing out.*

*[So, the controlling part is compensating for his helplessness?] No, I am saying that he probably has a controlling type personality, likes to be in charge and he is not in charge. [I am wondering if that can be exacerbated in times when you are feeling helpless? That you become more controlling of your environment to compensate for this inside feeling of "what in the world is going on here"] Well, yeah, absolutely, I mean you try to hold on to the control. Absolutely. But, it is a ... when you realize, you know in medicine you are not in control when you're sick or have some type of physical ailment, your body is in control. And, whenever he, inside he has that understanding, but it is a great source of anxiety that "I cannot just fix this." (015R, V2Q6)*

*2) He seemed to be a very demanding, overbearing at times, very argumentative. I would be very suspicious about this person. I have never come across somebody as belligerent as he: to just basically assume certain things about the clinic, about me, and so forth. I would be very cautious as far as keeping this person as a patient. (007R, V2Q6)*

***Second Prompt: What kind of feelings did this patient evoke in you?(V2Q7)***

**Categories from the Prompt and Example(s)**

1. The resident indicates no reaction/no feeling evoked by the interaction with the patient.

*I don't want to say feelings of anger at all. I don't want to say sympathetic, but empathetic. I do feel for him. "You might be going through something you don't understand and I'm here to help you." I don't want to be apathetic, I want to be hopefully ... to trust and believe that he has this pain. I'll do different things to try to get this thing resolved somehow or another to do the best to my ability to do what I can to do that. I am not going to be able to solve any problems personally, but, "Who can I send you to so you can get those problems addressed?" Not to really solve them, just address them. Person with back pain, "We are going to send you endocrinologist [not sure about that last word]." Or a person with nerve damage, we'll send to a neurosurgeon, a neurologist. I know who to send you to. They come here with this pain, "I don't know*

*what to do doc.” You as the doctor should know, “OK, I can have it worked up by somebody or something else.” A lot of it is just management of the disease. But, I don’t feel any resentment towards him because he is hurting and that is where his pain comes from. (005R, V2Q7)*

#### SELF-AWARENESS ORIENTED THEME

#### SELF-AWARENESS ORIENTED RESPONSE THEME – DEPENDENT-TYPE VIGNETTE

##### ***First Prompt: What is your overall reaction to this patient?(V1Q6)***

##### Categories from the Prompt and Example(s)

1. The resident recognizes Patient-Dynamics of dependence or anxiety and identifies her/his own reaction to the patient.

*My reaction is a sense of: first, if it’s a busy day, I would be annoyed by it because I would slow down with this patient and I’ll be a lot later than if I didn’t have to slow down for him. But, my sense is that there is an unlikely large cardiac component to the pain. Most likely, high anxiety component to it. When I say component, though, rarely do you get truly a complete psychiatric pain or a complete organic pain. So, he’s feeling something, but I have a tendency to lean towards: this is more likely anxiety pain. This particular patient is going to some time and reassurance. Frequent visits to meet what he needs. (010R)*

##### ***Second Prompt: What kind of feelings did this patient evoke in you?(V1Q7)***

##### Categories from the Prompt and Example(s)

1. The resident identifies some personal reaction to the patient.

*Sympathy and annoyance. (010R, V1Q7)*

#### SELF-AWARENESS ORIENTED RESPONSE THEME –

#### GUARDED/QUERULOUS-TYPE VIGNETTE

##### ***First Prompt: What is your overall reaction to this patient?(V2Q6)***

##### Categories from the Prompt and Example(s)

1. The resident is able to state her/his own personal reaction to the patient.

*He seemed to be a very demanding, overbearing at times, very argumentative. I would be very suspicious about this person. I have never come across somebody as belligerent as*

*he: to just basically assume certain things about the clinic, about me, and so forth. I would be very cautious as far as keeping this person as a patient. (V2Q6, 012R)*

***Second Prompt: What kind of feelings did this patient evoke in you?(V2Q7)***

Categories from the Prompt and Example(s)

1. V2Q7: The resident's reaction may be characterized by being stressed or anxious/frustrated.

*This is somebody who is going to be difficult. I had some anxiety in myself. [I had to specifically ask what she was feeling inside of herself in order to get this response.] Her own anxiety was related to a need for more information and that she has not had that much experience with this type (i.e., difficult) of patient. She noted that she does not want to get drawn into a confrontation. (002R, V2Q7)*

2. V2Q7: The resident provides a response indicating awareness of her/his own emotional reaction. This emotional response may be negative, but the resident is able to express it.

*Unappreciated. Annoyed. In some ways, nervous and intimidated.*

*When asked what 010R would do with these emotional reactions, he stated that he would recognize them in order to delay saying something too quickly. He noted that not recognizing these emotions may result in responses driven by these exact emotions. However, to know that they are there allows him to monitor them and react in a better way that builds a relationship.*

*010R also noted he is more likely to put the problem on the table rather than ignore it. That is, he would rather explore the anger and find its meaning rather than avoid it. (010R, V2Q7)*

*Summary of Results for Focus of Inquiry Research Question 3*

When asked for their reactions to and feelings experienced in reference to the “interaction” with the actor-patient in the video vignette, two themes emerged and are in keeping with the previous styles of responses to other research questions. Specifically, the categories suggested two themes: one being an awareness and expression of physicians’ personal reactions to the patient, and the other of maintaining a focus on patient variables while not acknowledging any personal awareness/disclosure of reactions. While some respondents acknowledged affective reactions to the actor-patient, others did not acknowledge the existence of a reaction at all. Those who did not identify a reaction to the actor-patient at times maintained the focus on the actor-patient himself. That is, even when asked about a personal reaction, the physician persists in discussing the patient and not her or his own self.

The theme of the categories that represent a greater self-awareness of reactions to and feelings that arose in experiencing this actor-patient is termed “Self-Awareness Oriented Theme.” The theme of categories that are in keeping with not having such an awareness or choosing not to disclose the reactions/feelings is termed “Patient-Only Reaction Oriented Theme.” The implication here is that the resident maintained focus on impressions of the patient rather than identifying more personal reactions to / feelings about the actor-patient.

The outline format for the presentation of results for Focus of Inquiry Research Question #4 is:

## **I. FOCUS OF INQUIRY RESEARCH QUESTION 4**

### **A. UNWILLINGNESS / HESITANT ORIENTED THEME**

1. UNWILLINGNESS / HESITANT ORIENTED THEME – DEPENDENT-TYPE AND  
GUARDED/QUERULOUS-TYPE

#### **a. *First Prompt***

1a. Categories from the Prompt and Example(s)

### **B. WILLINGNESS / OPENNESS ORIENTED THEME**

1. WILLINGNESS / OPENNESS ORIENTED THEME – DEPENDENT-TYPE AND  
GUARDED/QUERULOUS-TYPE

#### **a. *First Prompt***

1a. Categories from the Prompt and Example(s)

## **FOCUS OF INQUIRY RESEARCH QUESTION 4**

What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes in primary care settings?

The categories that emerged from the data for this focus of inquiry research question fall into two themes: an unwillingness or hesitancy to work with these patients or a willingness and openness to such interactions.

UNWILLINGNESS / HESITANT ORIENTED THEME

UNWILLINGNESS / HESITANT ORIENTED THEME – DEPENDENT-TYPE AND

GUARDED/QUERULOUS-TYPE

***First Prompt: What are your thoughts about working with patients with personality disorders in a primary care setting? (GQ1)***

Categories from the Prompt and Example(s)

1. The resident seems to perceive a limited role in dealing with personality disorders and prefers to refer the patient.

*I don't really feel comfortable completely about direct, overlooking of the care for the patient medicine-wise. So, I would probably refer them to someone like MHMR or like another professional like a psychiatrist for an evaluation and see what they recommend. I would love to have them in my practice still. As long as somebody else is following for their psychiatric medication or for BiPolar ... Personality disorders, again, I am not too up to date in the care of that style of person. I would adhere to have a psychologist or psychiatrist involved in that treatment. If they [psychologist or psychiatrist] think they are stable, I'll make sure they [patient] follow up with their psychiatrist. (005R, GQ1)*

WILLINGNESS / OPENNESS ORIENTED RESPONSE THEME

WILLINGNESS / OPENNESS ORIENTED RESPONSE THEME – DEPENDENT-TYPE AND

GUARDED/QUERULOUS-TYPE

***First Prompt: What are your thoughts about working with patients with personality disorders in a primary care setting?(GQ1)***

Categories from the Prompt and Example(s)

1. The resident is willing/openness to deal with personality disorder, but also may recognize her/his own limits and would consult or refer.

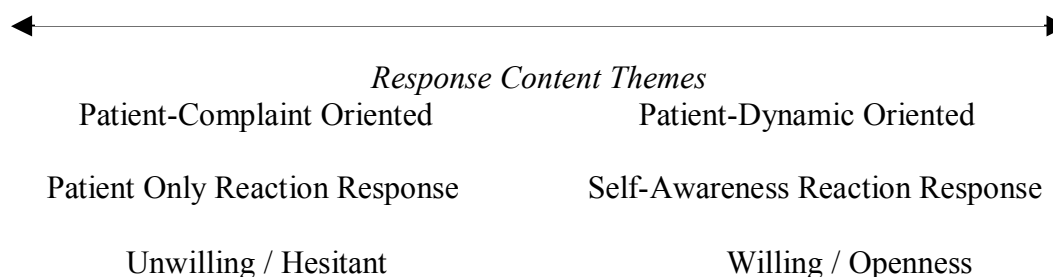
*I think it is part of the game. There is no way you can avoid it. From my little experience that I have. I am always dealing frequently with, for example, women, married women, who have abusive households. They don't come in and immediately tell you that. She is going to come in with some kind of somatic complaint.*

*This morning, I was with an orthopedist and he was saying, "I hate these people. They come in, these older people who come in all the time thinking that I can make them younger again. They got this pain and that pain and they just can't accept the fact that they are getting older." And, I said, "Well, they are probably here more for a little t.l.c." And, he said, "That is why I became an orthopedist and I didn't go into psychiatry." I said, "Well, there is no way you would make it in family practice."*

*So, I think it is definitely a role that family physician has to be aware of that psychosomatic diseases are real. In other words, it is as legitimate a problem as coronary artery disease. (006R, GQ1)*

*Summary of Results for Focus of Inquiry Research Question 4*

For this inquiry question, the response themes suggested that residents were either willing or unwilling/hesitant to work with patients with personality disorders in a primary care setting. Unwillingness or hesitant categories are aligned with the Patient-Complaint theme because the resident appears to prefer dealing with disease and not personality / dynamic-related concerns. Thus, the Willingness categories are aligned with the Patient-Dynamic theme as these responses suggest an openness to addressing patient issues/concerns apart from disease (see Figure 3).



*Figure 3. Continuum of Response Themes: Unwilling vs. Willing.*

## CHAPTER V

### CONCLUSIONS

#### *Overview of Conclusions Section*

This chapter will cover five primary areas of discussion. This will produce the final aspect of Lincoln and Guba's (1985) outline of naturalistic research: writing the theory that is grounded in the data. First, in reference to the framework presented in Chapter IV regarding the content of the residents' responses, I will outline a more comprehensive framework that will consider the possible effects of the content-based response styles and possible motivations behind the response styles.

During the course of gathering data and analyzing the information, a pattern seemed to emerge regarding the consistency of response styles. As such, the second main point will address the consistency of how residents responded from one question to the next. For example, were residents consistently patient-dynamic oriented or did they vacillate from one style to another (e.g., patient-complaint oriented)?

Third, in keeping with the notion of consistency, I will consider whether residents appeared to demonstrate consistency between their *ideas* about working with patients with personality disorders and what they actually *did*. Fourth, I will review possible implications of this study for medical education and comparison of the present study with previously reviewed research. And, finally, the limitations of this study will be addressed along with possible areas for further consideration.



### *A Comprehensive Framework*

One of my professors once explained the title of a book he had written: *A History of American Psychology* (Benjamin, 1992). He noted that he used the adjective “A” instead of “The” because his written perspective is just one of many possible perspectives of the history of psychology in America. As such, the framework/theory I discuss here is also one of many perspectives; hence, “*A Comprehensive Framework*”. I am sure that others would be able to suggest their own categories, themes and suppositions as to the effects of response styles as well as why the residents responded as they did in the interviews. Indeed, other perspectives would be welcomed additions to the discussion as a means to generate different ideas and recommendations to improve the quality of interactions between patients and physicians.

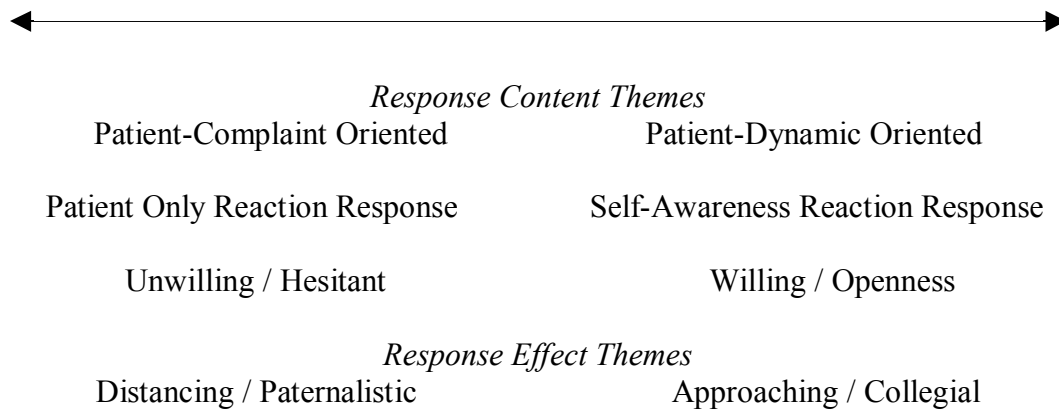
Further, as I mention in Chapter IV, the framework presented here is very basic. I chose this approach over a more fine-grained approach in keeping with a preference for a “less is more” style. I believe that a basic understanding may have a more applied impact. In the beginning stages of teaching, students are introduced to the basic principles of an area and are later introduced to greater detail within that area. For example, as I began to understand counseling skills, I was first introduced to the basic principles of active listening and showing empathy. Only after these basic areas were mastered could I move to more detailed understandings of counseling and the counseling relationship. However, I still turn to and rely on these basic areas. Thus, given that this study appears to be the first of its kind in developing an understanding of how primary care resident physicians work with personality disorder-type processes and characteristics (specifically, dependent-type and guarded/querulous-type), I believe that simplicity is the

first step to a more in-depth appreciation of this dynamic. Moreover, the use of a more basic approach may better translate into a paradigm for introducing medical students and experienced physicians to improved doctor-patient relationships.

In the Chapter IV, I presented the categories and themes of the residents' responses according to the content of those responses: whether they tended to address the patient's presenting physical complaint and/or other stated concerns (i.e., financial concerns) or whether the residents were more oriented towards the patient's dynamics (i.e., the dependency or anxiety of the patient). This content also included residents' tendencies, when asked about their own reactions to and feelings about the patient, to primarily discuss the patient or to identify and reveal their own more personal reactions to the patient. Finally, the themes also identified residents' hesitancy or willingness to work with patients with personality disorder-type characteristics and processes in a primary care setting.

#### *Possible Thematic Effects of the Responses*

In the first part of this section, I would like to consider the effects of the different response content-based themes noted above. That is, given the content (i.e., Patient-Complaint Oriented Theme or Patient-Dynamic Oriented Theme), what is a possible effect upon the interaction and relationship between physician and patient? After reviewing the information with a committee member familiar with personality disorders and primary care settings, we determined that the responses could be themed as either *distancing* the physician from the patient and/or acting in a *paternalistic* manner versus *approaching* and *engaging* the patient and/or acting in a more *collegial* manner. Figure 4 adds this dimension to the framework discussed in the results section.



patient's illness experience instead of just the disease and developing a collaborative effort towards treatment and healing.

An example of a resident response that keeps her/him apart from the patient's emotional concerns, effectively distancing them, may be found in (with "P" denoting patient statements/prompts in the video and "R" denoting the resident's response):

*P: "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me."*

*R: Yes, I would (have a comment for him). When the patient expressed himself that nobody in his family would believe him, but that he does have a strong family history of heart disease and that would be a big point there.*

*I think the global education of the patient ... the patient should be made aware that he is at high risk. I think that has not been conveyed to the patient. (011R, VIQ1)*

In this statement, the physician has perhaps ignored the patient's experience of not being heard by his own family and the focus is on educating the patient about the historical factors involved in coronary heart disease. While this may be an important understanding for any patient, the opportunity to open and explore the patient's personal experience of being ill is overlooked. By contrast, the following statement suggests how a resident approaches the same patient concern from a different perspective:

*P: "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me."*

*R: "Why would he say that? Why would he say that nobody believes him? What makes him feel that way? And, what don't they believe? (015R, VIQ1)*

Here, the physician has opened her or himself to the patient's assumptive world. The focus is squarely on the patient and his concerns. There is no mention of the physical symptoms, of educating the patient, or of setting boundaries. The focus is on gaining

greater insight into why the patient made the comment he made. The physician has approached and engaged the patient.

In another example the resident has apparently placed the responsibility for medical services on the patient.

*P: “Three hundred and fifty more dollars. And if that test doesn’t work? Then what? Another test? And then another test?”*

*R: I think at this point of the interview, the patient is getting a little aggressive, a little frustrated. Ultimately, getting to the point where he is frustrated with his primary care provider, looking for quick answers. I think at this point again I would redirect the patient towards his own responsibility and commitment because this is for the benefit of the patient. (011R, V2Q1)*

Here the resident perceives the patient as aggressive and highlights the patient’s responsibility in his own care. Not only does this type of response seem to distant the patient from the physician, but seems to absolve the physician of a sense of responsibility, thereby reducing the chance of establishing a more collaborative, collegial approach to treatment. However, the next example to the same prompt from the patient shows how a physician can try to engage the patient and work from a perspective that is based on the patient’s underlying concerns:

*P: “Three hundred and fifty more dollars. And if that test doesn’t work? Then what? Another test? And then another test?”*

*R: I need to know what your situation is. Whether this is your heart or not. Or else, I honestly cannot treat you. Then, try to figure out what it is that he is most worried about. Is he asking this out of a context of being broke or out of a context of being upset by something? I would try to find out what the source of his upset is. (010R, V2Q1)*

In this statement, the physician still addresses the physical concerns of the patient *and* wants to address what the patient is “most worried about.” Discussing “the source of his upset” does not seem to be a distancing intervention, but a more engaging one. Muschatt,

Cutler and Altman (1964) acknowledge the importance of working with patients' emotional concerns in the successful resolution of physical complaints, "For successful treatment of many cases of physical illness, attention to the psychological needs of the patient is essential, whether it is given consciously and by design or unconsciously and intuitively" (p. 207). By opening exploration of the patient's worries, the resident is attending to his psychological needs.

The above examples demonstrate how residents either distance from or engage with the patient based on responses given during the vignettes. Next, I consider how these two distinct themes are evident in how residents discuss ways they would establish relationships with the patient. The categories that emerged in reference to the question, "What would you do to establish a working relationship with this patient?" include:

1. The resident would engage the patient (V1Q10);
2. The resident is willing to work with and engage the patient (V2Q10);
3. The resident's focus is on setting boundaries and referring (although there may be some mention of the need to build rapport with the patient) (V1Q10); and,
4. The resident is not sure how to work with the patient or chooses to address finances only (V2Q10).

The first two categories (i.e., "The resident would engage the patient" and "The resident is willing to work with and engage the patient"), perhaps obvious by the definition of the category, suggest an inclination to address patient concerns and dynamics as evidenced by the resident's willingness to approach and engage the patient. Examples include:

*Q: What would you do to establish a working relationship with this patient?*

*R: Probably, because of this interview, I would try to have him in at least within the first 6 months every month just so that he knows that I will be there*

*for him as far as answering questions. Because of his dependent-like personality, just reassure him every time that he comes in. Provide him with the resource that we have here as far as with social services. Sometimes, just bringing him in just to talk and see how things are going would probably do wonders for the guy. And just talking about his social situation, see what is happening in his life: does he have any questions about other problems?*

*[Question: Why do you think that would do wonders for him?] Well, it just seems like a loner. Like he's just isolated, worried about what people are saying about him or what is going to happen to him next and such. I just kind of got the sense that there is something going on as far as underlying ... To get to the point where I feel comfortable as far as talking with him, talking about his medical problems, to the point where he has a good relationship with me and then moving to the next step as far as bringing in a psychologist or a psychiatrist to kind of assess his mental or social situation. (007R, VIQ10)*

Here, the resident has identified the “dependent” nature of the patient as well as his sense of isolation and suggests that more frequent visits may help alleviate the patient’s sense of uncertainty. Moreover, this resident demonstrates an openness to exploring areas beyond physical complaints and/or what the patient presents with. This resident suggests just talking with the patient, even more frequently, to get a sense of other aspects of his life. Again, this approach indicates the resident’s willingness to enter into the patient’s world and experiences rather than maintaining a safe distance from these dynamics and concerns. The resident also identifies the possibility of bringing in other assistance (i.e., psychologist or psychiatrist), but recognizes that a good, trusting relationship will need to be established before making such a referral.

A second example of approaching and engaging the patient is:

*Q: What would you do to establish a working relationship with this patient?*

*R: I think that being available helps. But you don't want to be too available. You don't want to give him your home phone and say, “Call me at midnight” because he seems like somebody who probably would.*

*Long-term wise, I think seeing him more often, even though the first time you meet him you don't know if you want to see all that often. But, I think seeing him on a more regular basis and establishing more of a relationship with him, showing him that you do want to help. I think that is important.*

*I think getting back to him ... If he has a test one day, he is not going to be one of those patients who want to sit at home and wait a week until his next visit with you. Calling him. Asking him if it's ok if the doctor leaves a message on the answering machine about the test results. A lot of time people will send out letters [about test results] and that takes 4 or 5 days. I don't think that in his case that will be the best for his state of mind.*

*By introducing him to your nurse would help. So, if you're not in the office, he will be able to talk to her on the phone. Maybe she can help alleviate some of his concerns. (004R, V1Q10)*

This example also demonstrates the resident's willingness to engage the patient. It suggests a proactive approach whereby the physician would initiate contact with the patient instead of placing the onus of contact on the patient. Granted, the resident does indicate some hesitancy to being too available to the patient by not wanting to provide a home phone number for him and acknowledges his own ambivalence about increasing contact (this self-awareness, discussed later, is actually a strength for the resident). Nonetheless, this response does support a general theme of engaging the patient. Moreover, it also suggests a more comprehensive approach to patient care by deliberately introducing him to the other staff such as nurses. This connects the patient with staff members so that he does not feel dependent only on one person. This may also serve to distribute some of the energy needed to care for this patient, but shares it in an approaching manner rather than sharing it through firing the patient from the practice or having the patient referred to another physician because the patient's underlying emotional needs are not met by this resident. Through such introductions to other staff,



the patient likely feels more connected and cared for, most likely increasing his trust of the health care team and improving adherence to treatment.

The third and fourth categories are representative of responses that most likely could distance the doctor from the patient. One example includes:

*Q: What would you do to establish a working relationship with this patient?*

*R: I would try to, like I said, you never know, I've had some patients like that. They start off like that and end up to be some of the nicest people, they are just having a bad day. If they continue to act like that, then I would tell him that he needs to find another physician because obviously he doesn't feel confident enough that we are providing the care that he came looking for. [Question: If his anger continues like that, what do you think is driving that anger? What is behind it, what is the point of that? If his complaint is not valid, but this is just the way he is, what do you think the anger is about?] He either has severe financial stress and he's just not directing it in the right direction or he has no respect for the opinion of the doctor or the expert physician role (008R, V2Q10)*

In this example, the resident would appear to disengage from the patient and seems to place the responsibility for a successful interaction on his shoulders. Although the resident acknowledges the possibility that the patient may be “having a bad day”, continued interactions like this one (as may be expected with a personality disorder in which relationship patterns are well established) could result in a referral to another physician. Moreover, when asked what could be behind the anger, the resident suggests that it is either financial stress (and should not be directed towards the physician) or that the patient just lacks respect for the physician. In either case, this response seems to resist identifying with the patient’s perspective and developing a deeper understanding of his dynamics and concerns.

Yet another distancing response:

*Q: What would you do to establish a working relationship with this patient?*

*R: Make sure he's compliant with what we ask him to do: medications, exercise regiment, his medical tests, whatever he has to do. If he is a needy patient, is he going to call me at all hours and all that? Then, tell him your office hours are this and that he cannot just pop in any time he wants. He has to call ahead of time, unless it truly is an emergency. [Question: Establishing some boundaries?] Exactly. (008R, VIQ10)*

Here again, this same resident distances her/his self from the patient. In this instance, the resident discusses the need to set firm boundaries to limit interactions with the patient.

The resident does not make mention of establishing a relationship or any kind of collaborative approach with the patient. With someone with dependent-type processes, such a response may be expected to only heighten a sense of abandonment. Moreover, noting an intention to make sure the patient is “compliant” suggests the more paternalistic medical approach. That is, the physician assumes the expert role in control and does not take a more collegial, collaborative approach to patient care.

A final example of distancing:

*Q: What would you do to establish a working relationship with this patient?*

*R: I would probably, he might turn out to have some coronary artery disease. In this case, scenario A, where he does turn out to have that (coronary artery disease), then I'll send him to the cardiologist, I'll have him cathed [catheterized?] and after the catheterization, I'll find out whether he is going to have to go to open-heart surgery or have his artery stented and then we'll put him on the right medication and tell him to stop smoking and reassure him that he is going to be fine as long as he follows a certain diet and certain exercise, no smoking, no drinking alcohol. And, then I'll have him follow-up with me the first 6 months, every month and then every 3 months and then twice a year. And then this is how I would establish my relationship with him. Scenario B: He does not have that (coronary artery disease), he turns out to have anxiety. I will treat him for anxiety. And, anxiety is very well treatable. I'll make sure he goes and sees a psychiatrist or a psychologist and put him on the right medication. The only reason I suggest the benzodiazepine at this point is that it is a short acting drug that acts right away on anxiety. Versus the other drugs that take 14 to 15 days to kick in. So, basically, I would probably start him on benzodiazepine and then knock it off as I am adding the other drugs which he can be on for a long term and then follow-up again on a*

*monthly basis, then 3 months and then 6 months. And this is how I would do it. (012R, V1Q10)*

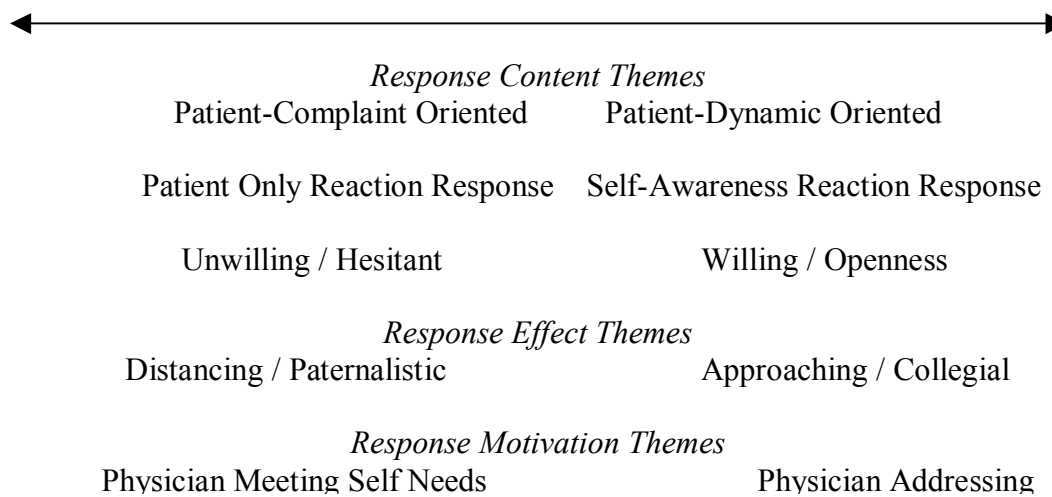
In this response, the resident suggests two possible scenarios in working with this patient. The first works with the physical complaints only. If this possibility of physical-based concerns is ruled-out through the tests, the resident then moves to the apparent anxiety. However, here the resident determines to refer the patient to a psychiatrist or psychologist for medication. While the physician speaks expertly about the medication options, this approach would seem to distance the physician from the resident. Care is shifted to another physician and medication is the intervention and no mention is made of establishing a relationship or engaging the patient in his care. The resident has well inoculated his/her self from responsibility in working with the patient.

#### *Possible Thematic Motives of the Responses*

The final layer of the framework addresses possible motivation behind the responses of the residents. That is, given the statements a physician made in response to the patient and the answers to questions about the vignettes and working with patients with personality disorder-type processes and characteristics, what may explain how the physician is thinking? James Bugental (1999), in his book *Psychotherapy Isn't What You Think*, notes that the content of *what* a person says or thinks is not as important as understanding *how* a person thinks. This understanding may afford the best opportunity to bring about change. So, the question becomes, why did the physicians say what they said?

Again, in reviewing the response styles of the residents with one of the committee members familiar with medicine and the context in which these residents work, an idea developed in response to this question. Essentially, in determining whether to address the

patient's physical problems or the patient himself, in effect distancing one's self from the patient or to approaching and engaging the patient, the physician may be operating from an assumption of whether to meet his or her own needs or to meet the needs of the patient. Figure 5 presents this final layer to the framework.



*Figure 5.* Continuum of Response Themes: Physician Needs vs. Patient Needs

Responses that tended to fall under the theme of “Physician Meeting Self Needs” seem to protect the resident from becoming too close or feeling too responsible for the patient. As such, these responses focus on physical concerns that the physician may feel she or he has expert knowledge of and is on safe grounds in addressing. Anything outside of that comfort zone may be overwhelming or even threatening to the resident. For example,

*P: “If you people don’t like patients, then why do you let patients even come here?”*

*R: I would say, “You are a little bit going over your limit. Let’s just stop right here and end this conversation. These are my recommendations.” Because,*

*you are doomed whether you say something or not. I would just stop it right there are probably leave the room. (012R, V2Q4)*

Or,

*P: "Three hundred and fifty more dollars. And if that test doesn't work? Then what? Another test? And then another test?"*

*R: He's not very trusting towards the doctor. He's saying that this test may not be necessary. He is saying, "How much is this going cost me?" Saying that, "I don't need this test so obviously. Why are you doing this test on me? This is just going to cost me money; that is all it is going to do." He is implying that money is what drives all tests.*

*[Question: What would you say to him specifically at this point?] I would probably just ... Obviously, he has a negative view towards my treatment, "Why this at this point?" I would sort of calm the situation and say, "You know, I am just doing this test because you came to me with chest pain. If the test doesn't show anything, is negative, then great and if it's positive, then we'll have to investigate a little more. My goal is to prevent a heart attack in you. You come in with chest pain, I have to make sure you don't have any illness that can cause a heart attack in the future when you're working or you're with your family."*

*I would ask him, "Do you want that or do you want us not to do anything? You might have a disease going on right now, but if you want us to investigate, that is your prerogative. You come to me for recommendations and my advice."*

*Again, put the ball in his court. Say, "You know, you're right." Make him think, "I came to you. I came to you for advice."*

*005R would then say, "You don't have to do it [the test]; you could or you couldn't. You could walk away right now." I will make sure I have heard myself to say, "I recommend you to do that, but if you don't want to do that, that is your prerogative. My goal is to help you."*

*I guess I need a little more tact. I don't want him to get more ticked off; just try to ease the situation and say, "You know, I am here to help you. I'm not here to make any money in the long run. These tests you are going to do, I'm not going to get any money out of it. I'm just going to see what happening to you."*

*005R then said that he would be open to "going down another road" if needed to find out what the patient's problem is. (005R, V2Q1)*

In each of these responses, the resident, by focusing primarily on physical concerns or by placing responsibility on the patient, appears to be protecting him or herself from joining with the patient to collaboratively define the problem and approach treatment. The message behind these responses seems to be, “Here is what *I* think the problem is, now what are *you* going to do about it?”

However, other resident responses demonstrated a theme of greater attention to the patient’s needs rather than her or his own needs. For example,

*P: “Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?”*

*R: I wouldn’t say anything. This is a time that calls for a careful pause. Let his frustrations be expressed completely. I can be very patient in cases like this. Some people just say, ‘Time out, my turn to talk’ and I’ll just let him keep talking. I might let him walk right out of the office. No charge ... Now, when he comes back and sues me, I still have a medical record that he was in the office.*

*I would ask him why he is so aggravated. “Why are you angry at me?” I think his response would be, “I am not angry at you. I am angry at the system.” I am sorry that the system doesn’t work 100% all the time, but I am still in a position to help you. I can still recommend and order the test that we feel are necessary.*

*I would emphasize the word “We”. He would say, “You have to agree to do this test. We are a team to try and help you. It is your decision to have these tests or not” And, I would try to diffuse the situation and make it less tense. (001R, V2Q2)*

Or,

*Q: What would you do to establish a working relationship with this patient?*

*R: Follow-up. Make sure I do follow-up with him. If I do tests, after the tests get the results back to him. Have the results on the table for the next time I see him. Call him after the test and tell him he’s fine or if he’s not fine, set up an appointment and we’ll make it sooner if we have to.*

*Calling is very important to keep that rapport open, especially if it is a difficult patient. Keep communication open.*

*Once you do something [wrong], they go somewhere else, they go to another doctor and find one that can help them. But, if you show that you are caring and you call them, their responsive and they respect that and they come back to see you. (005R, V2Q10)*

In each of these responses, the residents' focus seems to be on the patient and his needs rather than responding in a self-protective style. The resident, by approaching and engaging the patient in health care appears to be more in tune with meeting patient concerns rather than distancing and protecting her or his self from the patient. In the first response, the resident is willing to open her or his self to why the patient is angry. It would seem that a more self-protective response would be to avoid the anger rather than addressing it. Moreover, the resident emphasizes the importance of "We" in the response. Instead of disowning responsibility for the patient by placing it on the patient's shoulders, the resident enters into a collaborative approach for the patient's care.

The second response shows the resident's willingness to be more engaging with the patient. Instead of sticking with a set routine for office visits at predetermined intervals, despite the patient's apparent uncooperative presentation, the resident is willing to see the patient sooner if needed and to maintain consistent communication, although it may be tempting to limit that communication. The self-protective approach may be to distance and limit interaction as opposed to engaging the patient through more consistent and frequent contact. Moreover, the resident expresses concern that the patient may leave. Allowing him to do so would certainly be a more self-protective approach. Instead, in this case the resident wants to keep the patient engaged with him or her for his care.

### *Impact of Self-Awareness*

Another approach to considering whether the resident is distancing his or herself from the patient, and therefore acting more out of self-needs, or if he or she is approaching the patient and addressing the patient's needs, may be addressed by looking at the physician's level of self-awareness of reactions to the patient. Such an awareness of personal reactions and feelings may be useful in gaining greater insight into the patient's own psychological dynamics and improve the ability to engage with and relate to the patient and, therefore, addressing the patient's needs. As noted earlier, Bibring (1964) states,

If with some patients a good and effective relation cannot be established, this is not always because the doctor does not understand the patient, but rather because he does not understand his own reaction to the patient or to the situation. (p. 84)

Thus, awareness of one's own reaction may be an essential aspect of relating to a patient. Groves (1978) is another one of the earlier physicians to stress the importance of utilizing personal emotional reactions to patients diagnostically. To use those reactions the physician must first have an awareness of these feelings before they may be used in diagnosing a patient. By not recognizing one's emotional reaction to a patient, the physician possibly deprives him or herself of useful information, but can also be injurious to the doctor-patient relationship. For example, in discussing how physicians can cope with the hysterical female patient, Hollender and Shevitz (1978) state, "The physician is better off if he is aware of his feelings and copes with them by exercising conscious control than if his behavior is shaped by them but outside of his awareness" (p. 778). The message here is that physicians may invariably have an emotional response to their



patients. If they are aware of their affective reaction to a patient (either positive or negative), they may better control their interactions. However, if those feelings remain outside of conscious awareness, they may influence the physicians' thoughts and behaviors towards the patient. That the physician has an affective response is not the potential source of the problem; not being aware of, ignoring, or denying such a response may subject the physician to its very influence.

Gorlin and Zucker (1983) identify the following frequent physician emotional responses to patients identified as "hostile/borderline personality": taking patient hostility personally; hatred; or feeling authority threatened. The typical behavioral responses of the physician, based on these more subjective reactions, are: reciprocal hostility, rejection (power struggle, derision, forced discharge). They also cite the following emotional responses to the overly dependent patient: initial gratification followed by resentment, anger, impatience and guilt. The common behavioral response they identify as: hostility, abrupt distancing, and coldness (p. 1060). Thus, given these destructive consequences, it would seem that awareness of one's reaction and feelings about a patient would be essential first steps towards managing those reactions in a healthier manner.

In Chapter IV, responses were presented that indicated a lack of self-awareness (or at least a lack of willingness to vocalize a personal reaction). For example,

*Q: What is your overall reaction to this patient?*

*R: He is a difficult patient. He is a dependent and anxious patient. He seems like somebody with a lot of underlying psychiatric issues. I don't want to discount the chest pain, but there seems to be something else going on with the anxiety. 002R stated that she may try to address the physical and psychiatric issues at the same time. She would address the psychiatric concerns by trying to identify why he is worried. For example, she would inquire as to whether someone he knows or a family member recently had*

*similar medical problems and that this may be the cause of his anxiety. (002R, V1Q6)*

In this response the resident, when asked about *her* reaction to the patient, begins discussing *the patient* and not herself. In the following example, the resident denies any type of feeling or emotional reaction brought about by the patient,

*Q: What kind of feelings did this patient evoke in you?*

*“What do you mean by emotional response?” Did I feel sorry for the guy? [There is a whole range: mad, happy, sad, feel sorry for him. Did anything come up for you?] No. (007R, V1Q7)*

However, in the response below, the resident identifies his own reaction to the patient,

*Q: What kind of feelings did this patient evoke in you?*

*R: Unappreciated. Annoyed. In some ways, nervous and intimidated.*

*When asked what 010R would do with these emotional reactions, he stated that he would recognize them in order to delay saying something too quickly. He noted that not recognizing these emotions may result in responses driven by these exact emotions. However, to know that they are there allows him to monitor them and react in a better way that builds a relationship.*

*010R also noted he is more likely to put the problem on the table rather than ignore it. That is, he would rather explore the anger and find its meaning rather than avoid it. (010R, V2Q7)*

Here, the resident notes that by having an awareness of his feelings, he may avoid responses to the patient that grow out of these emotions. That is, it seems that if the emotions are not recognized, then they may inadvertently affect how the resident relates with the patient. Groves (1965/1965) states that the presence of negative emotional reactions to difficult (or what he refers to as “hateful”) patients may manifest in various ways: feelings of helplessness in the physician; “unconscious punishment of the patient”; “self-punishment by the doctor”; inappropriate confrontation between doctor and patient;

or “there may be a desperate attempt to avoid or to extrude the patient from the care-giving system” (p. 883). This last potential effect demonstrates the possibility for meeting the physician’s own needs instead of the patient’s needs if negative emotional reactions are not identified and addressed by the physician. Gorlin and Zucker (1983) state that when the physician acknowledges “his or her own emotional position, the doctor is able to consider the relationship with the patient more objectively” (p. 1059).

#### *Consistency of Residents’ Responses*

A question I began to ask myself as I reviewed and began categorizing residents’ responses was whether or not each resident’s responses generally kept to a consistent theme. To get a sense of any trends, I created tables that charted response themes for each resident across questions used for the analyses. Those tables may be found in Appendix AD. The tables list the response themes across the top and the questions along the side in rows. I placed an “X” to indicate how a resident’s response fit into the themes identified earlier.

Table 1 provides a general breakdown of the response consistency of residents’ responses to the vignette moments. That is, it looks only at the responses residents made to the actual vignette, not to the questions following the vignette or to the general questions. As such, this provides an overview of the consistency of style in a more immediate sense – how the resident appeared to respond to the patient. Column A, “Consistently Patient-Complaint”, provides a list of residents who consistently responded in a more Patient-Complaint, distancing, self-protecting manner; Column B, “Generally Consistently Patient-Complaint”, provides a list of residents who demonstrated the same kind of consistency but only had 1 or 2 responses that were more Patient-Dynamic

oriented. Column C, “Generally Consistently Patient-Dynamic”, provides a list of residents who were generally consistent in their Patient-Dynamic, approaching, patient needs style in all except 1 or 2 responses; and, Column D, “Consistently Patient-Dynamic”, provides a list of residents who were consistent in Patient-Dynamic orientation in each response. Residents whose responses were even less consistent are not marked on the table.

Table 1  
*Consistency of Resident Response Styles*

Resident	Column A	Column B	Column C	Column D
	Consistently Patient-Complaint	Generally Consistently Patient-Complaint	Generally Consistently Patient-Dynamic	Consistently Patient-Dynamic
001				
002				
003	X			
004		X		
005				
006		X		
007		X		
008		X		
009				
010			X	
011	X			
012	X			
013		X		
014	X			
015				

As can be seen by reviewing the table, four residents were consistently Patient-Complaint oriented in response style and none were consistently Patient-Dynamic oriented in their response style. Five residents had only one or two responses that did not consistently fit in the Patient-Complaint orientation. Only one resident had one response

that was not consistently Patient-Dynamic in orientation. Thus, it seems that no resident demonstrated a consistently patient-dynamic orientation, with only one coming close. If there is any trend, it is that relative consistency is only seen in more Patient-Complaint oriented styles. The implication seems to be that any consistency is more towards a distancing, self-protective style that focuses on physical complaints and not Patient-Dynamics and needs. The degree to which this is a conscious choice is unclear. This style would most likely not establish an effective doctor-patient relationship and could result in misdiagnosis, frustration for both patient and physician, and the patient, his underlying needs not being met, leaving the physician and beginning the same pattern with someone else.

*Do Residents Demonstrate Consistency Between Their Ideas and What They Did?*

This was another question that arose for me during the analyses. I became interested in gaining a sense of whether the residents practiced what they preached. To look at this more closely I decided to compare the consistency between themes of what the residents said they would do to establish a working relationship with the patient (responses to questions V1Q10 and V2Q10 – “How would you establish a working relationship with this patient?”) and themes of how they responded in the vignette (responses to questions V1Q1, V1Q2, V1Q3, V2Q1, V2Q2, and V2Q4). More precisely, I considered the consistency between V1Q10 and V1Q1, V1Q2, V1Q3 and the consistency between V2Q10 and V2Q1, V2Q2, V2Q4. Table 2 provides information regarding the consistency between these responses.

Table 2  
*Consistency Between Ideas and Responses*

Question:	V1Q1	V1Q2	V1Q3	V1Q10		V2Q1	V2Q2	V2Q4	V2Q10
Resident									
001	PC	PC	PC	PC		PC	PD	PD	PD
002	PC	PD	PC	PC		PC	PC	PC	PD
003	PC	PC	PC	PD		PC	PC	PC	PD
004	PC	PD	PC	PD		PC	PC	PC	PC
005	PD	PC	PC	PD		PC	PD	PC	PD
006	PC	PC	PC	PC		PD	PD	PC	PC
007	PD	PC	PC	PD		PC	PC	PC	PC
008	PC	PC	PC	PC		PD	PC	PC	PC
009	PD	PC	PC	PD		DNF	PD	N	PC
010	PD	PD	PC	PC		PD	PD	N	PD
011	PC	PC	PC	PC		PC	PC	PC	N/A
012	PC	PC	PC	PC		PC	PC	PC	PD
013	PD	PD	PC	PC		PC	PC	PC	PD
014	PC	PC	PC	PC		PC	PC	PC	PD
015	PD	PC	PC	PC		PC	PD	N	PD

*Note.* PC = Patient-Complaint Theme Response. PD = Patient-Dynamic Theme Response. N = Neutral Response. N/A = Question that was not asked due to time constraints. DNF = Did not fit a theme.

An overview of Table 2 does not provide a clear indication of consistency between how a resident responded in the vignette (as evidenced by response themes to questions posed during the vignette) and how a resident thinks she or he would respond (as evidenced by how a resident responded to a question about what she or he would do

to establish a working relationship with the patient). Out of thirty possible opportunities to identify consistency between residents' ideas of how they would establish a relationship with a patient and what they actually did in their responses to the vignettes, there were eight instances when residents demonstrated consistency within a given vignette between how they responded in the vignette and how they said they would respond. Of greater interest to me were the instances when residents' response styles that suggested a Patient-Dynamic orientation to establishing a relationship with a patient, but in actuality they tended to lean more towards a Patient-Complaint orientation in their responses during the vignette. This inconsistency occurred eleven times. For example, in the second vignette resident 013R, stated:

*Q: What would you do to establish a working relationship with this patient?*

*R: I would try to see him for more appointments. I would try to learn a little more about why he is angry. Maybe he had a bad experience with the health care system. Maybe this is just something having to do with his life right now. Maybe he lost his job and he doesn't have any money. If he has a financial issue and cannot pay for the visit, maybe we can work and get a payment plan. (013R, V2Q10)*

However, during the vignette, this resident provided the following:

*P: "Three hundred and fifty more dollars. And if that test doesn't work? Then what? Another test? And then another test?"*

*R: Yes, I would tell him that I understand that this is an expensive test, but that we need it because you are having problems with your heart and people can die from chest pain. I would educate him about that. (013R V2Q1)*

*P: "Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?"*

*R: I will tell him that you came here and I am responsible for you. You came in with chest pain. I am trying to do the best for you. I am dedicated to taking care of your health. I would talk to him and try to make him calm. I would*

*tell him that I understand that you are spending a lot of money, but I am also trying to do my best in doing my job. (013R, V2Q2)*

*P: “If you people don’t like patients, then why do you let patients even come here?”*

*R: I would just apologize and tell him that I am very sorry. Tell him that maybe I saw a very sick patient before him or something else that may have been the reason for running late. Explain the system and that I understand he is having to pay for parking and the doctor’s visit, but we are trying to do our best to take care of him. (013R, V2Q4)*

Here, the resident’s responses during the vignette represented a style that was more oriented towards dealing with the patient’s physical complaint. The resident seems focused on educating the patient, wanting to calm the patient, and establish an imbalance of power in stating “I am responsible for you” and “I am trying to do the best for you”. These responses seem to be placating and distancing and do not approach and engage the patient’s dynamics. Yet, when asked what she or he would do to establish a working relationship with the patient (i.e., an approaching engaging relationship geared towards meeting the patient’s needs), the resident states that she or he would try to see the patient more frequently or approach the emotion of anger and learn more about it.

These approaches were less evident in the actual exchanges in the vignettes, suggesting a degree of discontinuity between what the resident would intend to do and what she or he actually appeared to do. However, it is important to highlight here that this response style does contain some inclination towards establishing a working relationship. In the last response (V2Q4), the resident states she/he will be apologetic and show some empathy. As such, this style would be representative of the continuum of styles instead of the more dichotomous approach I favored in the analysis. Nonetheless, this resident has demonstrated a leaning towards a more distancing style.



This trend seems to suggest that residents may have the intention to meet patient needs by approaching and engaging the patient, thus addressing psychological concerns and dynamics. But, for whatever reason, residents were unable to operationalize that stated intent. This could be attributed to one or a combination of the following: a lack of understanding of how to do that; a self-protective style; or negative reactions to patients that exert a stronger influence over stated intentions. In any case, this issue may best be addressed in medical education of students, residents, and practitioners.

#### *Comparison of Findings with the Literature*

Given the findings of this study, the question then becomes: How do these results compare to what I found in the extant literature? As noted earlier, Hueston, Mainous, and Schilling (1996) state that primary care physicians frequently only address patients' physical complaints, resulting in under-diagnosis or lack of emphasis placed upon patients' emotional and behavioral concerns and needs. This present study seems to support this possibility. Here, one of the main themes discussed is a tendency to address physical complaints and concerns rather than dynamic variables such as emotional needs. As Hueston, Mainous and Schilling warn, the consequence of choosing to focus primarily on physical issues can lead to unnecessary increased utilization of medical services. One possible effect of patients continuously seeking new physicians until underlying concerns and needs are identified and addressed is increased medical costs.

Previous research has shown that patients tend to provide physicians with more cues for their informational needs than emotional needs ("Cancer Patients' Emotional Needs", 2002). Moreover, it was found that the physicians were more adept at identifying the informational needs over the emotional concerns of the patients. Again,

this present study lends some credibility to this tendency. Perhaps the patient's own focus on informational needs provides the physician an opportunity to demonstrate her or his expertise and meet those needs. As such, it may be that the physician is really meeting her or his own needs by maintaining the image of the expert. However, the potentially more nebulous and uncertain area of emotionally-based concerns are ignored. As some residents demonstrated in this study, there are times when the physician chooses to identify and discuss psychological variables although specific cues for those concerns may not be forthcoming.

Moreover, as Wiener and Nathanson (as cited in Sanson-Fisher & Maguire, 1980) have demonstrated, young physicians tend towards an interview style that avoids patient disclosure of emotional problems. Thus, a more deliberate approach towards addressing patient psychological variables is needed. As discussed earlier, this preference may be attributable to a lack of knowledge/skill to know what to do with psychological and emotional content when it is identified (Goldberg, Jenkins, Millar & Faragher, 1993). Again, it may be that such an approach that tends to avoid areas of uncertainty is driven more by self-protectiveness that precludes a preference for patient needs.

A further possible contributing factor that explores why physicians may tend towards a more physical-complaint orientation is Bowman's (1998) contention that the absence of psychodynamic concepts in the medical field prohibits reasoning that would include the possibility of psychological or emotional etiologies of physical problems. This is where further research in the development of a greater understanding of these specific doctor-patient interactions is warranted. Building on this initial basic

framework, investigation could explore the physician's perspective and physician variables affecting these relationships.

Finally, these results appear to support Pare and Rosenbluth's (1999) contention that a physician's awareness of emotional reaction to a patient may be utilized to understand the patient as well as in formulating diagnostic opinions. However, there were two apparent trends within the physician responses. First, some physicians demonstrated an ability to identify and acknowledge personal reactions to the patient. Second, and perhaps more commonly, other physicians chose to focus on the patient variables when asked about their *own* reaction to the patient. Further consideration of why residents did not identify their own reactions/feelings when asked would be warranted. Perhaps some are unable/unwilling to identify their own reactions, others may be concerned with maintaining an image of being unaffected by the patient, and still others may experience uncertainty about what those reactions may mean and how they may affect their work.

#### *Possible Implications for Medical Education*

The results of this study seem to suggest a need to educate residents about how to work with patients with personality disorder-type characteristics and processes. Results suggest that some residents are able to identify and work with underlying emotions and psychological dynamics. However, there is inconsistency when this approach is made and, more often, there was a trend towards addressing patient physical complaints and logistical concerns that could distant the patient from the physician. Given the established importance of developing an effective and trusting relationship with patients,

recognizing and working with the psychological dynamics of these patients appears to be an essential aspect of treatment.

Indeed, The Committee on Behavioral and Social Sciences in Medical School Curricula (Board on Neuroscience and Behavioral Health, Institute of Medicine, 2004), recommended improvements in medical education that included the statement: “Medical students should be provided with an integrated curriculum in the behavioral and social sciences throughout the 4 years of medical school” (p. 64). One of the domains identified for inclusion in the curricula is “physician-patient interaction”, and listed as “high priorities” for focus are basic and complex communication skills. Moreover, the report listed as medium priority “management of difficult or problematic physician-patient interactions” (p. 65). Specifically, the report recommends, “Students should understand ... how analysis of their own reactions to patients can help them recognize possible somatoform disorders in the patients. They should also understand how to use the physician-patient relationship as a therapeutic tool for these patients” (pp. 70 – 71).

Muschatt, Cutler and Altman (1964) have demonstrated the effectiveness of a medical class that explores psychological concepts and includes a focus on self-awareness of the students’ own psychological processes. The results of their class included an increased comfort in medical students’ ability to work with patients’ emotional concerns. They noted the initial inhibition about working with these concepts, “In all groups [of physicians being trained] there was evidence of considerable anxiety about the use of psychological investigation and treatment” (p. 218). However, the result of the training physicians received in this area was reported as, “all remarked on their greater tolerance and patience with individuals with emotional problems, and on their

greater tolerance of themselves and of their own emotional conflicts into which they had acquired some insight” (p. 228). Moreover, Muschatt, Cutler and Altman note,

One aspect of the changed attitude in regard to history-taking stems from the value that affective insight into psychological development has in helping the physicians to be less afraid of a psychological closeness to their patients. Some of the doctors have remarked on their awareness of having become less involved with patients through identification, so that they feel that they can be more objective. From very early in the courses, we became aware of the doctors’ strong unconscious fears of their patients’ dependency on them, even though such dependency is a prerequisite for successful medical treatment. (p. 228)

Thus, it seems that these researchers also note the tendency (even unconscious tendency) for physicians to distance themselves from patients – especially when dependency is experienced. Further, they also recognize the importance of some dependency. That is, for treatment to be successful, the physician must not be afraid of approaching and engaging the patient, perhaps even to the extent that some healthy dependency is established.

It has been established that physician negative affective reactions may adversely impact the development of a relationship with patients (Gorlin & Zucker, 1983). Smith (1984, 1986) has found that medical students and primary care trainees can experience negative feelings such as anger and fear towards their patients – as was revealed by some of the responses in this study. However, Smith also found that, regardless of experience level, physicians did not have an awareness of these feelings. In their own study of emotional reactions to patients, Smith and Zimny (1988) found that the emotional

reactions board-certified internists had to patients “did not decrease as the internists gained more experience” (p. 395). The conclusion may then be that such awareness must be taught and can not be learned via on-the-job training. In fact, Smith and Zimny (1988) note that the research by both Gorlin and Zucker (1983) and Smith (1984, 1986) has led to the conclusion that the “feelings of physicians ... should be addressed in teaching” (p. 393) medical students.

Therefore, it would seem that the themes of this study are supported by previous research. A concerted effort to introduce medical students and residents to psychological concepts, instruction in how to recognize and handle those psychological variables, and guidance in how to increase awareness and use of one’s own reaction to patients would be warranted. Such instruction and guidance may alleviate the need to self-protect against feeling overwhelmed by patient personality dynamics and needs. Moreover, as the physician learns to approach the patient rather than create distance, the relationship between doctor and patient may improve, leading to more collaborative treatment, and, possibly, improved outcomes.

#### *Limitations of the Study and Areas for Further Consideration*

As is the general application of naturalistic research, this study has endeavored to create some understanding of a previously un-described phenomenon. Here, the interactions between residents and patients with personality disorder-type characteristics and processes in a primary care setting were analyzed in hopes of developing a basic theory as to what these interactions look like and what may be some guidelines for understanding how those interactions develop.

Although the methods and results of this study have been audited and found to be trustworthy, there are some areas that could be improved upon. First, this study utilized a video vignette portraying an actor-patient to which participants responded. While this was most likely the best approximation of the interaction being studied given Institutional Review Board and other ethical restrictions, a better understanding of this area would be achieved with analysis of actual interactions between physicians and patients. The residents who participated in this study may have been influenced by the responses they heard the physician in making the video-vignette. They may also have been influenced by the start and stop nature of the interview (given that the video would be stopped to allow the resident time to respond to the actor-patient), perhaps disrupting a more natural flow to these interactions. Finally, given that interviews could only be conducted during the lunch hour of the residents, there were some time constraints that were unavoidable. As such, there were occasions when questions were omitted in order to try to acquire what I had deemed to be the more important responses. Nonetheless, in spite of these limitations, I believe that at least an initial understanding of what these interactions look like and what may contribute to the themes that emerged has been achieved through this effort.

This initial framework may also provide some indication of future areas to consider within this area. First, a more in-depth understanding of what influences residents' style of interaction would be prudent. Such an understanding would contribute to better interventions to improve medical education and training. Second, I believe that a better understanding is needed of how residents conceptualize personality disorders. While some residents were able to articulate an understanding of disrupted relationship

patterns and distorted sense of identity common to personality disorders, others focused more on some of the behavioral manifestations of these personality structures (i.e., anxiety, frustration, anger). As discussed earlier, improving awareness and understanding of psychological constructs may improve comfort in addressing these areas with patients. Third, this research addressed a relatively short time interval in which the residents were exposed to the video vignette. Further research should consider how these relationship patterns emerge over time. What occurs in this initial interview may be very different over time. As mentioned in the discussion of what personality disorders are, the diagnosis of a personality disorder is usually made when a pattern of this personality style is evident over time. Thus, residents' perceptions and interactions may indeed change as they have more interactions with these patients.

There will emerge more areas for research as these different avenues are pursued. As with the emergent nature of the design of the naturalistic approach, this relatively unstudied type of interaction in medicine will emerge as new research and information and understandings are developed.



### *Summary*

In summary, this research has sought to explore the interactions between primary care physicians and patients with personality disorder-type characteristics and processes. My hope has been to develop an idea of “what it looks like” when physicians interact with personality disordered patients. Using a naturalistic qualitative design, I have sought to identify possible themes that may describe the interaction styles of resident primary care physicians when working with patients with personality disorder-type characteristics and processes, specifically dependent-type and guarded/querulous-type styles. Moreover, I have also tried to identify some preliminary ideas as to the effects of the different physician interaction styles and possible explanations as to why these themes emerge.

While I could not naturally observe these interactions in person, I best approximated these exchanges through the use of a video of a patient demonstrating these various traits and asking each physician to respond to specific moments in the video and then to discuss reactions to the actor-patient in the video as well as provide some thoughts about working with this population of patients. By categorizing participants’ responses to specific questions into homogeneous groups with heterogeneity between groups I sought to allow the data to “speak for itself.” That is, in keeping with naturalistic paradigms, I wanted to enter the study with no fixed ideas but to allow the data to serve as the foundation for a theory about these observations.

In reference to the focus of inquiry research questions, two broad themes emerged from the data and categories of the data. First, when the content of residents’ responses to “interactions” with the actor-patient in the video is analyzed, there appears to emerge a

tendency to either direct attention to the patient's presenting physical concern and to establish firm boundaries and identify solutions to concerns or, there is a theme of residents attempting to identify and potentially address underlying psychological and emotional concerns of the patient.

Second, residents appear to characterize the establishment of a relationship with this patient population as either a distancing, paternalistic approach, or an engaging and dynamic relationship style. Finally, residents also appear to be either aware of and willing to address their own reactions to patients or they demonstrate a tendency to not discuss personal reactions, choosing instead to discuss patient variables. And, residents also showed a dichotomous response to willingness to work with this patient population. While some were hesitant and less willing to do so, others indicated a desire to engage and attempt to work with these patients.

In addition to exploring the content-based material, I also attempted to identify a framework for understanding the possible effects of these styles as well as motivating variables behind these styles. With regards to effects of response styles, content styles that tended to be more patient-complaint oriented resulted in an apparent distancing between physician and patient. However, response styles that addressed patient dynamics appeared to result in a more engaging and collegial interaction style. In working with a physician familiar with the content and context of this study, a possible framework centered on whether the resident was driven by self-needs or patient-needs arose. The former style suggests a self-protective style that inoculates the resident from any negative interactions by distancing and being more paternalistic in addressing physical complaints of the patient. The latter indicates a drive to identify and address

patient needs. In doing so, the physician and patient are more engaged and have the perhaps greater opportunity to identify and work with underlying emotional needs.

In closing, as mentioned several times, this interpretation of the data is just that, an interpretation. Moreover, it is a very basic interpretation. The intention of this investigation was to see what a specific interaction looks like. Others who review the same data as I have, will invariably reach some similar and some very dissimilar results, conclusions, and implications. I have striven to adhere to the rigor of naturalistic inquiry so as to establish the trustworthiness of the findings here. Having the availability and input of a physician familiar with the content and context of this study assisted in developing an initial framework that may be applied to understanding and education in this area.

## REFERENCES

- Alderson, P. (1998). The importance of theories in health care [Electronic version]. *BMJ*, 317, 1007 – 1010.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed). Washington, DC: Author.
- Anstett, R. (1980). The difficult patient and the physician-patient relationship. *The Journal of Family Practice*, 11, 281 – 286.
- Balint, M. (April, 1955). The doctor, his patient, and the illness. *The Lancet*, 683 – 688.
- Barbour, R. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? [Electronic version]. *BMJ*, 322, 1115 – 1117.
- Barry, K., Fleming, M., Manwell, L., & Copeland, L. (1997). Conduct disorder and antisocial personality in adult primary care patients. *Journal of Family Practice*, 54, 151 – 158.
- Benjamin, L. T. (Ed.). (1992). *A history of American psychology*. Special centennial issue of the *American psychologist*. Washington, DC: American Psychological Association.
- Bibring, G. (1964). Psychiatry and medical practice in a general hospital. In N. E. Zinberg (Ed.), *Psychiatry and medical practice in a general hospital* (pp. 75 – 87). New York: International Universities Press, Inc. (Reprinted from *New England Journal of Medicine*, 254, pp. 366 – 372, February 1956)
- Bowman, E. S. (1998). Pseudoseizures. *Psychiatric clinics of North America*, 21, 649 – 657.

- Bugental, J. (1999). *Psychotherapy isn't what you think*. Phoenix: Zeig, Tucker & Theisen, Inc.
- Cancer patients' emotional needs often undetected by oncologists. (2002, March 1). PsycPORT.com. Retrieved March 1, 2002, from <http://www.psycport.com>.
- Dhossche, D. M., & Shevitz, S. A. (1999). Assessment and importance of personality disorders in medical patients: An update. *Southern Medical Journal*, 92, 546 – 556.
- Emerson, J., Pankratz, L., Joos, S., & Smith, S. (1994). Personality disorders in problematic medical patients. *Psychosomatics*, 35, 469 – 473.
- Friedman, H. S. & Booth-Kewley, S. (1987). The “disease-prone personality”: a meta-analytic view of the construct. *American Psychologist*, 42, 539 – 555.
- Girón, M., Manjón-Arce, P., Puerto-Barber, J., Sanchez-Garcia, E., & Gómez-Beneyto, M. (1998). Clinical interview skills and identification of emotional disorders in primary care. *American Journal of Psychiatry*, 155, 530 – 535.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Goetz, J. P., & LeCompte, M. D. (1981). Ethnographic research and the problem of data reduction. *Anthropology and Education Quarterly*, 12, 51 – 70.
- Goldberg, D. P., Jenkins, L., Millar, T., & Faragher, E. B. (1993). The ability of trainee general practitioners to identify psychological distress among their patients. *Psychological Medicine*, 23, 185 – 193.
- Goodwin, J.M., Goodwin, J.S., & Kellner, R. (1979). Psychiatric symptoms in disliked medical patients. *Journal of the American Medical Association*, 241, 1117 – 1120.

- Gorlin, R.; & Zucker, H.D. (1983). Physicians' reactions to patients: a key to teaching humanistic medicine. *New England Journal of Medicine*, 308, 1059 – 1063.
- Green, J., & Britten, N. (1998). Qualitative research and evidence based medicine [Electronic version]. *BMJ*, 316, 1230 – 1232.
- Greenberg, R. P. (2000). Common psychosocial factors in psychiatric drug therapy. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The role of common factors in medicine: the heart and soul of change* (pp. 297 - 328). Washington DC: American Psychological Association.
- Gross, R., Olfson, M., Gameroff, M., Shea, S., Feder, A., Fuentes, M., Lantigua, R., & Weissman, M. (2002). Borderline personality disorder in primary care. *Archives of Internal Medicine*, 162, 53 – 60.
- Groves, J. (1978). Taking care of the hateful patient. *The New England Journal of Medicine*, 298 16, 883 – 887.
- Gutheil, T. G., (1985). Medicolegal pitfalls in the treatment of borderline patients. *American Journal of Psychiatry*, 142, 9 – 14).
- Hahn, S., Thompson, K., Wills, T., Stern, V., & Budner, N. (1994). The difficult doctor-patient relationship: somatization, personality and psychopathology. *Journal of Clinical Epidemiology*, 47, 647 – 657.
- Halpern, E. S. (1983). *Auditing naturalistic inquiries: the development and application of a model*. Unpublished doctoral dissertation, Indiana University.
- Hamilton, J., Decker, N., & Rumbaut, R. (1986). The manipulative patient. *American Journal of Psychotherapy*, XL 2, 189 – 200.

- Helman, C. G., (1985). Communication in primary care: the role of patient and practitioner explanatory models. *Social Science Medicine*, 20, 923 – 931.
- Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling* (2<sup>nd</sup> ed.). Boston: Brooks/Cole.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25, 517 – 572.
- Hollender, M.; & Shevitz, S. (1978). The seductive patient. *Southern Medical Journal*, 71, 776 – 778.
- Hueston, W., Mainous, A., & Schilling, R. (1996). Patients with personality disorders: functional status, health care utilization and satisfaction with care. *The Journal of Family Practice*, 42, 54 – 60.
- Hyler, S. E., & Rieder, R. C. (1987). *Personality diagnostic questionnaire – revised*. New York: New York Psychiatric Institute.
- Kahana, R. J., & Bibring, G. L. (1964). Personality types in medical management. In Zinberg, N., (Ed.) *Psychiatry in medical practice*. New York: International University Press; 1964: 108 – 123.
- Kobasa, S. C. (1979). Stressful life events, personality, and health: an inquiry into hardiness. *Journal of Personality & Social Psychology*, 37, 1 – 11.
- Kolb, J.E., & Gunderson, J.G. (1980). Diagnosing borderline patients with a semi-structured interview. *Archives of General Psychiatry*, 37, 37 – 41.
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings from the National Institute of Mental Health

- Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64, 532 – 539.
- Kuzel, A. J. (1998). Naturalistic inquiry: an appropriate model for family medicine. *Family Medicine*, 30, 665 – 671.
- Lambert, H., & McKevitt, C. (2002). Anthropology in health research: from qualitative methods to multi-disciplinarity. *BMJ*, 325, 210 – 213.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Maffei, C., Fossati, A., Rinaldi, F., & Riva, E. (1994). Personality disorders and psychopathologic symptoms in patients with androgenetic alopecia. *Archives of Dermatology*, 30, 868 – 872.
- Miller, M. C. (2001). Advances in the pathophysiology and treatment of psychiatric disorders: implications for internal medicine. *Medical Clinics of North America*, 85. Retrieved February 24, 2002, from <http://home.medconsult.com/das/arti...50125&sid=87338784/N/216913/1/html>.
- Moyers, B. (Ed.). (1993). *Healing and the mind*. New York: Doubleday.
- Mushatt, C., Cutler, R., & Altman, H. (1964). Teaching dynamic-psychological principles and their application to general medical care. In Zinberg, N., (Ed.) *Psychiatry in Medical Practice*. (pp. 205 – 230). New York: International University Press.
- Nowlis, D. P. (1990). Borderline personality disorder in primary care. *The Journal of Family Practice*, 30, 329 – 335.



- Oldham, J. M. (1994). Personality disorders: current perspectives. *Journal of the American Medical Association*, 272, 1770 – 1776.
- Pare, M. F., & Rosenbluth, M. (June, 1999). Personality disorders in primary care. *Primary Care; Clinics in Office Practice*, 26 (2). Retrieved February 24, 2002, from <http://www.mdconsult.com/das/journal/view/20038904/N/10734963?ja=144747&PAGE-1.html&ANCHOR=top&source=MI>.
- Patton, M. Q. (1980). *Qualitative evaluation methods*. Beverly Hills, CA: Sage.
- Rubino, I. A., Sonnino, A., Pezzarossa, B., Ciani, N., & Bassi, R. (1995) Personality disorders and psychiatric symptoms in psoriasis. *Psychological Reports*, 77, 547-553.
- Sanson-Fisher, R.; & Maguire, P. (September, 1980). Should skills in communicating with patients be taught in medical school? *The Lancet*, 523 – 526.
- Sansone, R. A., Whitecar, P., Meier, B. P., & Murry, A. (2001). The prevalence of borderline personality among primary care patients with chronic pain. *General Hospital Psychiatry*, 23, 193 – 197.
- Sansone, R. A., Wiederman, M. W., & Sansone, L. A. (1998). The Self-Harm Inventory (SHI): development of a scale for identifying self-destructive behaviors and borderline personality disorder. *Journal of Clinical Psychology*, 54, 973 – 983.
- Schafer, S., & Nowlis, D. (1998). Personality disorders among difficult patients. *Archives of Family Medicine*, 7, 126 – 129.
- Schneidt, K. S., (2000). Borderline personality disorder in primary care: recognizing signs and symptoms. *Journal of the American Academy of Physician Assistants*, 13, 19 – 39.

- Schwarcz, G., & Halaris, A., (1984). Identifying and managing borderline personality patients. *American Family Physician*, 29, 203 – 208.
- Schwenk, T., Marquez, J., Lefever, D., & Cohen, M. (1989). Physician and patient determinants of difficult physician-patient relationships. *The Journal of Family Practice*, 28, 59 – 63.
- Scovern, A. (2000). The role of common factors in medicine. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The role of common factors in medicine: the heart and soul of change* (pp. 259 – 295). Washington DC: American Psychological Association.
- Searight, H. R. (1992). Borderline personality disorder: diagnosis and management in primary care. *The Journal of Family Practice*, 34, 605 – 612.
- Smith, R.C. (1984). Teaching interviewing skills to medical students: the issue of “countertransference.” *Journal of Medical Education*, 59, 582 – 588.
- Smith, R.C. (1986). Unrecognized responses and feelings of residents and fellows during interviews of patients. *Journal of Medical Education*, 61, 982 – 984.
- Smith, R.C., Lyles, J.S., Mettler, J. A., Marshall, A. A., Van Egeren, L. F., Stoffelmayr, B. E., Osborn, G. G., & Shebroe, V. (1995). A strategy for improving patient satisfaction by the intensive training of residents in psychosocial medicine: a controlled, randomized study. *Academic Medicine*, 70, 729 – 732.
- Smith, R.C., & Zimney, G.H. (1988). Physicians’ emotional reactions to patients. *Psychosomatics*, 29, 392 – 397.
- Smith, R. J., & Steindler, E. M. (1983). The impact of difficult patients upon treaters: consequences and remedies. *Bulletin of the Menninger Clinic*, 47, 107 – 116.

- Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal*, 152, 1423 – 1433.
- Surwit, R. S., Feinglos, M. N., & Scovern, A. W. (March, 1983). Diabetes and behavior: a paradigm for health psychology. *American Psychologist*, 255 – 262.

APPENDIX A  
INTERVIEW QUESTIONS

VIGNETTE 1:

1. "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me."
2. "You'll be there when I have this won't you?"
3. "So I can call you at any time?"
4. "It's not like I'm so kind of a drug addict. Just something mild."
5. "I think it's starting to hurt a little bit now."
6. What is your overall reaction to this patient?
7. What kind of feelings did this patient evoke in you?
8. How did you react to praise or expressions placing you in such high esteem?
9. How did you react to expressions of weakness or helplessness?
10. What would you do to establish a working relationship with this patient?
11. How would you describe this patient to another physician?
12. Which of these Kahana personality types do you think this patient represents?

## VIGNETTE 2:

1. “And if that test doesn’t work? Then what? Another test? And then another test?”
2. “Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?”
3. “I trust you people to come up with an opinion and tell me what to do?”
4. “If you people don’t like patients, then why do you let patients even come here?”
5. “What choice do I have? I have to go along with what you say?”
6. What is your overall reaction to this patient?
7. What kind of feelings did this patient evoke in you?
8. How did you react to the patient’s challenging statements? (Such as, “If you people don’t like patients, then why do you let patients even come here?”)
9. To what extent did you feel that you had to defend yourself with this patient?
10. What would you do to establish a working relationship with this patient?
11. How would you describe this patient to another physician?
12. Which of these Kahana personality types do you think this patient represents?

## GENERAL QUESTIONS:

1. What are your thoughts about working with patients with personality disorders in a primary care setting?
2. How comfortable are you in identifying these patients?
3. What are key characteristics you look for in identifying personality disordered patients, specifically, patients with Borderline Personality Disorder?
4. Would you want any further training in being able to successfully work with these patients?
5. Which of these patients would you be more comfortable working with?
6. Is there anything that I haven't asked you about that seems important?

## APPENDIX B

## QUESTIONS ADDED DURING THE COURSE OF THE INVESTIGATION

1. What kind of qualities do you think a primary care physician would need to work with somebody who is borderline or has a personality disorder? (GQE1)
2. Once you realize that you have somebody like this, somebody who is borderline, does that change your treatment approach or your conceptualization of the patient? (GQE2)
3. Does the patient need something else from his physician other than care for the physical symptoms? (V1QE1)
4. Do you think that this patient may be looking for something more from you than medical care? (V2QE1)

## APPENDIX C

## LETTER OF ATTESTATION FROM AUDITOR

April 27, 2002

This letter is to attest to the data audit work on the dissertation by James Deegear entitled, "Understanding How Primary Care Physicians Work with Personality Disordered Patients: A Qualitative Approach."

I am a practicing psychiatrist with the Brazos Valley Residency Program and Department Head for the Leadership in Medicine Program in the College of Medicine in the Texas A&M University System Health Science Center. Based on my background as a psychiatrist who has worked with personality disordered patients and my affiliation with the Residency Program, I believe that I have the expertise needed to understand this patient population and familiarity with the setting where this research was conducted that allows me to serve as auditor of this project. Based on this role, I was able not only to establish the trustworthiness of the results, but was also able to assist James in the analysis and understanding of the information that emerged in the results.

I have been involved with this process since its initial stages and have consulted with James on a number of occasions in developing the organization of the study. At the outset of the study and after the first four interviews were conducted and I reviewed some of the transcripts, I assisted James in refining his interview format and questions asked of the residents.

As auditor of the data and analysis, I reviewed categorizations of the units of data and the definition of the categories with James on two separate occasions. As a part of this process, I reviewed each transcribed unit for goodness of fit with the assigned category and associated definition. During this process, I was able to work with James on refining some of the categories and combine categories on several occasions to create greater heterogeneity of categories. Moreover, I assisted James in developing his understanding of what the themes may mean for the area he investigated.

In reviewing James' organization of the data and supporting information, I found that the identified themes may be easily linked to the individual pieces of data units that serve as the foundation of the framework that emerged from the results. The information was well organized and marked and easily accessible.

I believe that James has met the requirements necessary for me to determine that these results are trustworthy and amenable to interpretation and application to other similar contexts.

Sincerely,  
Richard DeVaul, M.D.



## APPENDIX D

FOCUS OF INQUIRY RESEARCH QUESTIONS AND SPECIFIC INTERVIEW  
QUESTIONS USED IN THE ANALYSIS

Research questions and the interview questions used for analysis:

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:
  - a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

*VIQ1, "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me."*

*VIQ2, "You'll be there when I have this won't you?"*

*VIQ3 "So I can call you at any time?"*

- b. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes.

*V2Q1, "And if that test doesn't work? Then what? Another test? And then another test?"*

*V2Q2, "Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?"*

*V2Q4 "If you people don't like patients, then why do you let patients even come here?"*

2. What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes?

*V1Q10, What would you do to establish a working relationship with this patient?*

*V2Q10 What would you do to establish a working relationship with this patient?*

*And, added questions: "What kind of qualities do you think a primary care physician would need to work with somebody who has a personality disorder?" and,*

*"When you realize that you have a patient with a PD, does that change how you conceptualize the patient and treatment?"*

3. What are some themes suggestive of how resident primary care physicians' characterize their reactions to patients with personality disorder-type characteristics and processes?

*V1Q6, What is your overall reaction to this patient?*

*V1Q7, What kind of feelings did this patient evoke in you?*

*V2Q6, What is your overall reaction to this patient?*

*V2Q7 What kind of feelings did this patient evoke in you?*

4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes in primary care settings?

*GQ1 What are your thoughts about working with patients with personality disorders in a primary care setting?*

APPENDIX E

PATIENT-COMPLAINT ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 1A

What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

**CATEGORIES**

1. Resident deals only with the physical symptoms.
2. Resident identifies confusion and anxiety of the patient and tries to clarify a plan of action.
3. The goal of the response is to “educate the patient” to reduce his anxiety.
4. The resident indicates that he/she will not be there, but will consult with the physician who will help.
5. The resident indicates that she/he will try her/his best to be there.
6. Resident indicates that the patient may call the clinic/answering service to get in touch with her/him.
7. Resident states that it is ok to call and tries to educate the patient.

APPENDIX F

PATIENT-DYNAMIC ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 1A

What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes?

**CATEGORIES**

1. Resident gets more background information – especially why the family did not believe the patient.
2. The resident indicates that she/he will try her/his best to be there and acknowledges patient's anxiousness/dependent style.

## APPENDIX G

### PATIENT-COMPLAINT ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:
  - b. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (Guarded/Querulous-Type) characteristics and processes.

### CATEGORIES

1. The resident places the responsibility for treatment on the patient.
2. The resident states that the tests are medically necessary – educating the patient.
3. The resident emphasizes dealing with monetary concerns of the patient.
4. The resident is putting the responsibility for treatment on the patient.
5. The resident explains the clinic's procedure for seeing patients.
6. The resident confronts the patient.
7. The resident apologizes to the patient and explains the system.
8. The resident does not apologize and states that the patient has a choice to leave or to stay.

APPENDIX H

PATIENT-DYNAMIC ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 1B

What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- b. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (Guarded/Querulous-Type) characteristics and processes.

**CATEGORIES**

1. The resident directly addresses the patient's apparent emotional reaction.
2. The resident acknowledges the patient's emotions and tries to work with the patient.

Neutral-Oriented Response

1. Resident lets the patient vent anger and listens.

APPENDIX I

PATIENT-COMPLAINT ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 2

2. What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

**CATEGORIES**

1. The resident focuses on setting boundaries and referring. There may be some mention of building rapport.
2. The resident is not sure how to work with the patient or chooses to address finances only.
3. The resident stated a need to be patient, understanding and setting boundaries.
4. The resident would change how she/he communicates.

## APPENDIX J

### PATIENT-DYNAMIC ORIENTED THEME FOR FOCUS OF INQUIRY RESEARCH QUESTION 2

2. What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

### CATEGORIES

1. The resident would engage the patient with things such as more frequent visits.
2. The resident is willing to work with the patient and engage him. Interventions range from: boundary setting; seeing the patient more frequently; validating the patient; establishing trust; and helping the patient understand the process.
3. The resident suggests patients, insight into personality disorders, and self-awareness.
4. The resident would question the patient's physical complaints and suspect some alternative non-physical reason for the physical complaints.



APPENDIX K

PATIENT-ONLY REACTION ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 3

3. What are some themes suggestive of how resident primary care physicians characterize their reactions to patients with personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

**CATEGORIES**

1. The resident identifies Patient-Dynamics (i.e., anxiety), but not his/her own reaction to the patient.
2. The resident indicates no stated emotional reaction to the patient.
3. The resident states what her/his reaction is NOT.
4. The resident's reaction is solely about the patient: 1) Figuring out Patient-Dynamics and working with those; or, 2) Identifies patient problems, but not determine how to work with those.
5. The resident indicates no reaction/no feeling evoked by the interaction with the patient.

APPENDIX L

SELF-AWARENESS ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 3

3. What are some themes suggestive of how resident primary care physicians characterize their reactions to patients with personality disorder-type characteristics and processes typical of dependent-type and guarded/querulous-type styles?

**CATEGORIES**

1. The resident recognizes Patient-Dynamics of dependence or anxiety and identifies her/his own reaction to the patient.
2. The resident identifies some personal reaction to the patient.
3. The resident is able to state her/his own personal reaction to the patient.
4. The resident's reaction may be characterized by being stressed or anxious/frustrated.
5. The resident provides a response indicating awareness of her/his own emotional reaction. This emotional response may be negative, but the resident is able to express it.

**APPENDIX M****UNWILLINGNESS / HESITANT ORIENTED THEME FOR****FOCUS OF INQUIRY RESEARCH QUESTION 4**

4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes in primary care settings?

**CATEGORIES**

1. The resident seems to perceive a limited role in dealing with personality disorders and prefers to refer the patient.

APPENDIX N

WILLINGNESS / OPENNESS ORIENTED THEME FOR  
FOCUS OF INQUIRY RESEARCH QUESTION 4

4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes in primary care settings?

**CATEGORIES**

1. The resident is willing/openness to deal with personality disorder, but also may recognize her/his own limits and would consult or refer.

## APPENDIX O

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A V1Q1

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

*Vignette 1, Question 1*

*Prompt: "I know I'm going to be ok with you taking care of me. I'm just so relieved because nobody in my family would believe me."*

**Category: Resident deals only with the physical symptoms.**

002R

He definitely has a problem. I need to validate to him that he has some kind of problem. I need to "stratify his risk factors" for heart disease. I want to explain to him that the next step is a stress test and then look for any other problems that may be present [speaking of physical problems here].

004R

I would say, "Obviously you are one of my patients. I need to take pretty much everything you say at face value. We can certainly do some tests to find out if you are having chest pain for a certain reason."

011R

Yes, I would (have a comment for him). When the patient expressed himself that nobody in his family would believe him, but that he does have a strong family history of heart disease and that would be a big point there.

I think the global education of the patient ... the patient should be made aware that he is at high risk. I think that has not been conveyed to the patient.

012R

I would say, "Thank you very much for trusting me and putting your trust in me."

**Category: Resident identifies confusion and anxiety of the patient and tries to clarify a plan of action (defining what happened).**

001R

The first statement from the patient was that 'I am putting my entire care into your hands' and now the doctor is telling him 'It is not going to be me caring for you.' That obviously is the cause of a lot of anxiety.

I don't think he [patient] is really concerned about his pain right at this moment, it's 'I really need someone to take care of me and now you're telling me you're not going to take care of me.'

There is discontinuity between doctor and patient.

The doctor is saying 'I am going to refer you to another doctor. I don't know who, I know where, but I won't be there with you.' The patient is going to walk out of that room and have chest pain again just because of that.

In response to if the patient could call you at any time, I would say, 'Yes, you can call me at anytime, but if I may not be the one to be able to come to your immediate aid.' 001R agreed that this was role clarification.

003R

He seemed kind of confused.

I would say that we do not know for sure if you have something now, but we will do the stress test and we will find out if you really have something to confirm that. At this point we do not know yet.

006R

"I'm kind of concerned that he is anxious."

"I think at this point I would probably reiterate that we don't have a diagnosis and that his symptoms are atypical and that there isn't a definitive diagnosis and try to kind of alleviate (*sic* as in alleviate) his anxiety."

008R

008R would not say anything to the patient at this moment. "I would let him keep talking."

014R

I would just let him continue speaking.



**Category: Resident gets more background information – especially why family did not believe him.**

005R

I would ask him, “How long has it been going on?” Obviously he has had told people about this before. Obviously in the past, his family at least hasn’t believed him. Now, why would they not believe him? I would be thinking that as well. Has been faking other illnesses in the past?

I (the patient) am glad you’re believing me as opposed to others who have not believed me in the past. Investigate that [this statement by the patient] a little bit more.

007R

I would say, “What do you mean by people not believing what type of symptoms that you’re having?”

I would want to inquire what does he mean by the question.

Then I would certainly ask about his social situation as far as with his family, his relationship with the family members. That would probably be the main ...

Certainly, just the way he responded with his facial expressions, I would get a pretty detailed work environment: is he working, not working. What does he do in his spare time? Is he married, single, divorced? Just based on that, a very detailed social and family history.

009R

“Can you tell me more about why nobody would believe you?”

010R

I would probably listen further to find out what he means by, “nobody in my family believes me” what it is that they didn’t believe. I would ask him to elaborate a little bit.

I don’t think I would feel comfortable saying, “Oh, yeah it (the patient’s problem) is real” because I need to know what it is that he’s really worried about.

013R

I would ask him to explain what he meant that nobody would believe him. Why is that because I would think a family would be supportive? Find out what are the family dynamics: who is his family? Does he have a wife and kids? What about his parents? How old are his children?

015R

“Why would he say that? Why would he say that nobody believes him?”

“What makes him feel that way?”

“And, what don’t they believe?”

## APPENDIX P

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A V1Q2

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:
  - a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

*Vignette 1, Question 2*

*Prompt: "You'll be there when I have this won't you?"*

**Category: The goal seems to be to "educate the patient" to reduce anxiety.**

001R

"The impression is one of a lot of anxiety, concern."

I would re-explain the purpose of the test again, and again, and again "until the patient is comfortable in understanding completely."

"It takes time, but it is time well worth spent."

When he grabbed his chest in reference to walking on the treadmill, "I wonder if there is a mental component to this" and that would go along with the way the patient sees that his family has "brushed him off."

I don't mean that if there is a mental component that it needs to be brushed off, "but is obviously a part of his appearance as a patient to me."

I would keep trying to ask him questions to find out if he fully understands what I need to do.

005R

I would say, "Not necessarily will I be there. There will be a specialist there assisting you." If I did it in my own office, I would be there obviously. Usually, we send them to a cardiologist and have a specialist follow him there.

Obviously, he sounds a little bit worried. So, I would ask, "Are you worried about something happening? Have you had one [a stress test] before? You seem a little anxious about this test?" And, I would then see what his response would be and work with that. See if he had any questions.

I would ask him if I had answered his questions or not about what that test is going to be. "I don't want to stick you [the patient] with anything, just let me explain a little bit more about what the test is." It will stress his heart and he would walk on a treadmill. I would explain a little more detail about the exam. Maybe he had one before and just doesn't remember it.

007R

He seems like a very dependent person.

Very slow. I would want to what kind of education level he has.

He is very nervous with his movements. Kind of like a child-like response as far as his questions: "What does it entail?", "Will you be there?" type of thing.

[Question: What would you say to him when he ask you, "You'll be there won't you?"] I would carefully say what I'll be doing. I would certainly say that I would be there because I would be the one administering the exam.

I would explain to him that he would have to return and I would go through the same process as far explaining the procedure and would certainly explain some of the risks and benefits of the test just to get a feel of how he would respond to that.

The way his gestures and mannerisms, he asking so many questions about every single detail "is just not right."

He definitely has a personality disorder as far as it being atypical chest pain. But, you certainly have to rule-out cardiac disease, especially in a 44 year old tobacco user with strong family history.

But, I would just kind of ...

It sounds like he, I don't know what education level he is at, but I would try to explain to him at his level.

011R

I think the patient has some element of ignorance as far as the test is concerned. Like I said initially, I would educate the patient. First of all, I would reiterate that he is high risk because of the fact that he has a lot of risk factors that predispose him to heart problems. Secondly, I would kind of be more general ... I mean, usually, I would give him a pamphlet to read and understand what a stress test is and seek some more information and then tell him that I am going to schedule it.

I would just not dive into it. People generally get scared, patients especially, if they are not informed. And, I think he still needs some information to make an informed decision. I think that process is lacking. The physician just dives in by saying, "I am going to rule-out that you don't have heart problems, but I am going to schedule this test to check your hear." I think that is fine, but I think he needs to go a little more into depth as far as the stress test and educate the patient. I think patient education is vital. That allays a lot of anxiety and prepares the patient. I think that the preparation is not there (in the video).

**Category: Resident indicates that he/she will not be there, but will consult with physician who will help (missing the point).**

003R

I would explain to him that I will not be able to be there because he will be under the care of his cardiologist, the specialist in that field, and he will explain to the patient the details of the procedure.

009R

“Yes.”

009R then spoke again after the video continued: Did you say that I or the cardiologist would be there? [He was asking if you would be there.] I would be there. Oh, I was thinking that the cardiologist would attend. Going back to the question, I would say, “Probably not because it is not necessary that I am there for this type of test.”

014R

Usually, this is a test done by the cardiologist and the cardiologist is the one that is present at the stress test and there is a nurse there. And, if there are any questions that you may have at that time, they’ll be happy to answer them. This is something that they do on a regular basis, they have experience in this.

If you have any questions about it before hand, I’ll be glad to explain it to you.

015R

I would say, “More than likely I would not be able to be there whenever you had it. I am actually going to be calling the cardiologist to help him and I with this problem. He is a very good cardiologist and he will keep me up to date on everything that is going on, but this would actually be in his office.”

**Category: Resident indicates that she/he will try their best to be there.**

006R

“If it is my personal patient, I would certainly try to be there if I can. “

“Especially being a resident, I don’t know if you can be there when you’re in private practice.” (laughing)

“I have had several people in that position and it is rather reassuring. They like to see a familiar face.”

008R

“Depending on how the office is set up, if I was capable of being there, certainly I would.”

012R

I would say, “If I’m not tied up in the clinic or in a procedure, I would definitely do my best to be there.”

**Category: Resident indicates that she/he will try their best to be there AND acknowledges patient's anxiousness/dependent style.**

002R

I would explain to him that I am sending him to another doctor for these tests. [002R indicated that she would not be with the patient for the test.]

I would want to help relieve any anxiety he may be having.

004R

Well, sometimes we actually do the stress here at the clinic, so it depends on if he was actually going to go to a cardiologist and have that done. If it was going to be done at somebody else's office, I think it would be odd for me to show up at that office and be there at the same time.

In this guy's case, you might need to do that. [Question: What do you mean?] He seems kind of anxious and seems to be on the anxious side.

I would certainly say (hopefully I have worked with the cardiologist before), "I highly recommend Dr. X, he is a great doctor and he will be there during the test and he will certainly get the results to me as soon as we can and I will talk with him. The chances aren't good that if it is done somewhere else that I would be there at the same time."

010R

It is a different circumstance because I do these tests and yes, I would be there, because I would be doing the tests.

However, my response to him if I were sending him to a cardiologist would be, "I won't be there that day, but I'll see you soon thereafter." He's obviously worried, obviously anxious about the outcome of the test.

013R

I think that he is very anxious. He is scared of the stress test. I don't think he understands.



[Question: Would you tell him that you would be there?] It depends on my schedule. If I see my patient as pretty anxious, I would try to be there. I would try to be there to support him.

## APPENDIX Q

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1A VQ3

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- a. Themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (dependent type) characteristics and processes.

*Vignette 1, Question 3*

*Prompt: "So I can call you at any time?"*

**Category: Resident indicates that patient may call clinic/answering service to get in touch with him/her.**

001R

The first statement from the patient was that 'I am putting my entire care into your hands' and now the doctor is telling him 'It is not going to be me caring for you.' That obviously is the cause of a lot of anxiety.

I don't think he [patient] is really concerned about his pain right at this moment, it's 'I really need someone to take care of me and now you're telling me you're not going to take care of me.'

There is discontinuity between doctor and patient.

The doctor is saying 'I am going to refer you to another doctor. I don't know who, I know where, but I won't be there with you.' The patient is going to walk out of that room and have chest pain again just because of that.

In response to if the patient could call you at any time, I would say, 'Yes, you can call me at anytime, but if I may not be the one to be able to come to your immediate aid.' 001R agreed that this was role clarification.

002R

I would tell him that a doctor is on-call 24 hours a day as with this clinic [Brazos Valley Residency Clinic].

[She provided no indication that she herself would be available nor did she address his underlying need for contact/dependence.]

003R

If the symptoms get worse, then he can call the office at any time or come in to the ER if symptoms get worse.

004R

004R would say, "You can certainly always call the clinic and they can either leave a message or get a note to me. If it's not during clinic hours, in the middle of the night, you can certainly call the on-call service or you can call the ER and they can certainly give you advice as to what you should do at that moment."

006R

"Yeah, I mean, he could call me at any time. I could always be reached by beeper."

"I wouldn't give him my home phone number."

I also would tell him that if it did get worse, then I would give him the symptomology of if he was having an acute coronary syndrome and tell him to go to the ER.

[So, things to look for?] Exactly.

008R

"Sure."

[Question: Sure, call any time?] "Call the office and they'll call me."

009R

Can I think or do I have to respond immediately. [Whatever works for you.]

“Yes. We have an answering service and they will let me know (if the patient calls). However, if your chest pain gets more and more frequent, then you have to go to the ER.”

012R

“Definitely.”

013R

He can call me at any time. I would tell him that there is an answering service, so I would respond to his phone call any time. We cannot be on-call all the time; that is impossible.

014R

I would say, “If your chest pain does happen to get worse and you feel that it is something that you need to be concerned about, feel free to call me. And, if you feel like this may be an emergent type of situation, then call 911 because they have a quicker response to emergencies.”

015R

I would say, “I will be available as much as I can, but if I’m not here in the office, you can talk to one of my nurses who will contact me. And, I will get back to you as soon as possible.”

**Category: Resident states that it is ok to call AND elects to educate the patient.**

005R

I would ask him, "Yeah, you can call answering service if you have any further questions or problems."

Again, he is very apprehensive about doing this test or making sure that I am there.

Also, I would want to know a little more history about where he is in mental status: an idea of his I.Q., his educational status, because I have patients who are like this also. She is MR, borderline MR, with an IQ probably less than 70, asking same questions like this.

You reassure the patient, "You're not going to die with this. With you're symptoms we should rule-out ischemia of the heart."

He asked about food and should he exercise. Those things I would also answer, say some other causes of this chest pain could be reflux that is worse with spicy foods, so let's lay off spicy foods. Educate him on that. When he asked about doing exercise, "You know, don't go and overdo yourself and be sore the next day. Just do regular activities, just don't go and run a marathon or anything like that."

So, again the education. Where this guy is, the lack of education, the lack of knowledge, he seems very anxious about this test. And, we just educate the patient most of the time about what is going to be done and who is going to do it. Make it a little more calm and they can deal a little better with the situation. Because in your mind, the doctor, you're like, "OK, it is a simple test", but in their mind they are going, "Oh my gosh, what is happening to me?" You know, just go down to their level and explain to them in as much detail as possible, but not too much detail that you get them more confused.

007R

I would specifically tell him what things to look for as far as pain, intense pain, shortness of breath, diaphoresis; explain to him what type of symptoms that we would be looking for that would consider more of a cardiac-type problem.

Certainly, I would try to explain to him that if he was certainly having like a panic attack or if he was worried, he could certainly try to reach the office. If not, he can leave a message if he really doesn't think that this was cardiac. If he felt overwhelming doom to the point to where he has never had this before or he's had these symptoms, I would certainly tell him to just go straight to the emergency room and have a doctor assess if he is unable to reach me.

010R

“You can call my office at any time. Either I or someone will get back with you, either my nurse or myself or my colleague.”

Probably also start looking at giving him something more tangible to hold on to. That’s a harder thing to ... that’s something you can code in the data very easily. [Question: What do you mean by “tangible”?] That’s why you can’t code it in the data. (010R seems to be saying that there is something more (i.e., tangible) he would do, but is unable to say exactly what that is at this time. It varies from person to person depending on the circumstance. I have patients that deal with this type of attachment anxiety, features of dependence.

011R

Here again, it is all a matter of patient education.

The doctor (in the video) gives the false sense of reassurance to the patient that “you can call me anytime”. Now, if the patient is undergoing a stress test and during the process of the test, he begins to undergo any changes, the doctor should tell him that, “You are going to be monitored throughout the test and you are going to have people there who are trained to look after you as part of the process and you’ll have a cardiologist who does the test.” So, I think issues of informing the patient are lacking (in the video) and preparing the patient and the patient is not well educated.

## APPENDIX R

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q1

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- b. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 2, Question 1*

*Prompt: “And if that test doesn’t work? Then what? Another test? And then another test?”*

**Category: Resident places the responsibility on the patient – he has the choice.**

002R

I would tell him that there are certain “standards of care” that I must adhere to. There is an “algorithm” that must be followed within that standard of care that dictates procedures to follow. I am “obligated to do certain things.”

I would let him know that it is his prerogative to do the test or not; he has a choice in whether or not to do the test. [When asked, she explained that the choice is that she as a doctor can only suggest tests. As a part of empowering the patient, he has the choice of taking the test or not taking the test.]

She also noted that she would tell him that if the tests are negative, this may help provide some reassurance to him that there may not be anything significantly wrong with him.

005R

Obviously, he is a little more talkative.

He's not very trusting towards the doctor. He's saying that this test may not be necessary. He is saying, "How much is this going to cost me?" Saying that, "I don't need this test so obviously. Why are you doing this test on me? This is just going to cost me money; that is all it is going to do." He is implying that money is what drives all tests.

[Question: What would you say to him specifically at this point?] I would probably just ... Obviously, he has a negative view towards my treatment, "Why this at this point?" I would sort of calm the situation and say, "You know, I am just doing this test because you came to me with chest pain. If the test doesn't show anything, is negative, then great and if it's positive, then we'll have to investigate a little more. My goal is to prevent a heart attack in you. You come in with chest pain, I have to make sure you don't have any illness that can cause a heart attack in the future when you're working or you're with your family."

I would ask him, "Do you want that or do you want us not to do anything? You might have a disease going on right now, but if you want us to investigate, that is your prerogative. You come to me for recommendations and my advice."

Again, put the ball in his court. Say, "You know, you're right." Make him think, "I came to you. I came to you for advice."

005R would then say, "You don't have to do it [the test]; you could or you couldn't. You could walk away right now." I will make sure I have heard myself to say, "I recommend you to do that, but if you don't want to do that, that is your prerogative. My goal is to help you."

I guess I need a little more tact. I don't want him to get more ticked off; just try to ease the situation and say, "You know, I am here to help you. I'm not here to make any money in the long run. These tests you are going to do, I'm not going to get any money out of it. I'm just going to see what's happening to you."

005R then said that he would be open to "going down another road" if needed to find out what the patient's problem is.

006R

[It took some moments before 006R responded.]

I think at this point in time I would explain the reasoning behind the testing and how you eliminate categories.

And reassure him that I am not wasting his money or I wouldn't do it; which I wouldn't (waste his money).



These are the reasons, the rationales, for why I am doing each one of these tests.

And, of course, I would let him know that he has the ability to ... that he doesn't have to have them if he doesn't really want them.

011R

I think at this point of the interview, the patient is getting a little aggressive, a little frustrated. Ultimately, getting to the point where he is frustrated with his primary care provider, looking for quick answers. I think at this point again I would redirect the patient towards his own responsibility and commitment because this is for the benefit of the patient.

**Category: Resident states that the tests are medically necessary – educating the patient.**

003R

He is a little bit aggressive. It seems like he does not trust. I wouldn't say antisocial, but he is getting there.

[Question: What would you say to this statement?]

It is very important, that we need to find out if your heart is functioning, to have the test screen in order to find out if your heart is ok, so we can treat.

This is a question of medical necessity; it is not a luxury.

007R

Certainly there is a stopping point. But, because of his past medical problems and risk factors, we have to basically rule-out the most severe problem which would be cardiac disease. And, if it takes more tests to basically rule that out, I think it would probably be best in the long run for him. Because, the worst case scenario is he having a heart attack and we certainly want to know if he has those risk factors for a cardiac problem. And, we want to make sure he is on the right medication.

013R

Yes, I would tell him that I understand that this is an expensive test, but that we need it because you are having problems with your heart and people can die from chest pain. I would educate him about that.

014R

Basically these are just exams to be sure and to rule out anything that could be detrimental to his health. However, if the tests that are recommended at this point come back negative, then something else may need to be done. There will not be any unnecessary tests. We need to continue to watch his health and see if there is any other cause for his chest pain.

015R

These patients are a bit more difficult than the dependent patient.

Reiterate that I am working as well as I can with my medical knowledge and expertise to help him come to a solution. I am unable to make the diagnoses without these tests.

And, I would not order anything that is unnecessary.

**Category: Resident emphasizes dealing with monetary concerns – “we will find money for the tests you need”.**

001R

After he said 350 more dollars, I would have asked him for more history, for more information. “This does not tell me enough. Maybe he did go to the emergency room and have some whopping bill.”

I would say, “If it is important to you to know the cause of the pain, it’s an expense worth paying for. If financial concern is a problem, we can get in contact with the hospital, social services, personnel and billing personnel to find out what methods we can use to decrease or spread out the financial level. We have whatever means in our office to assist with paying the medical bills.” Suggested the patient talk with his employer if he is employed. “If the test result does not provide us with an answer, then we will just have to discuss what other options to pursue after we have that information.”

004R

I would say, “What you’re coming here for is not uncommon as far as chest pain. There is a certain way we go about evaluating that. I would advise you that you have this stress test done. Based on those results, we’ll make the next step. You certainly don’t have to take my advice. It’s going to be your responsibility as how far you want to take this. If money is an issue, there are ways that we can help pay for this. We can certainly set you up with a social worker and see if there is any financial aid that you can get. I don’t think the money issue should be the most important reason that we do or do not do this test.”

012R

I would ask, “Let’s talk a bit about your financial situation: How much you can and cannot afford. Let’s probably hook you up with a social worker who can help you get those tests for free by getting some help.” I’ve never had a problem getting any patient any studies, probably they had to wait. Those are not issues for me because I would calm him down and then I’ll tell him a way that we can work on this.

**Category: Resident directly addresses patient's anger.**

008R

I might tell him that I notice that he is a little hostile.

Ask him, try to get out of him if he's been through a lot of tests that he had to pay for.

I don't know how to phrase it, but I'd ask him where did this anger come from.

Maybe he did go to the hospital and had a whole bunch of tests and ended up with a \$5,000 bill and they said, "Oh, there's nothing wrong with you."

[Question: So, just getting to the source of what the anger is about?] Yes, I would ask him, "I notice you're a little angry about this, tell me why."

010R

"I need to know what your situation is. Whether this is your heart or not. Or else, I honestly cannot treat you."

Then, try to figure out what it is that he is most worried about. Is he asking this out of a context of being broke or out of a context of being upset by something? I would try to find out what the source of his upset is.

## APPENDIX S

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q2

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

- b. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 2, Question 2*

*Prompt: Do you gang up and plan this so I come to see you and then another doctor and another doctor, and you each get your fair share?"*

**Category: Resident is putting responsibility on the patient. Resident does not seem to be in touch with his/her own or patient's emotional variables.**

004R

You could try and explain to him that if everyone with chest pain went straight to the cardiologist, they would be working 24 hours a day and still couldn't see everybody. I don't think in this case that would be the best response to him. Again, you could just say, "It doesn't matter what you should have done or shouldn't have done, the point is that right now my recommendation is that you get this stress test done and this is how we need to go about doing it."

005R

Obviously, he is a little more combative. He's obviously very irritable as well.

He could have a lot of frustration also. He could have had this whole work-up before. If he had anything going on, I would say, "Why are you so upset about ... so against us trying to do a test on you?"

Again, I would educate this patient on the test. He would say to the patient, "I don't want to be doing something you don't need."

007R

This is his first time here, correct? [Correct.] Ok. Certainly, I would try to explain to him that he basically came on his terms to come to this clinic to be assessed and I'm going to do the best that I know to treat this problem or at least assess this problem. And, unfortunately, this is the chain of events that have to occur. Certainly, if he had a previous relationship with the cardiologist, he could probably easily make that visit. In certain situations with the insurance, you have to go through the loops in order to see the specialist. And so, I would just try to reiterate that to him that unfortunately that in certain aspects of medicine, that is how the system works. He may be very upset with what is going on, but I would just try to reassure him that I will do my best.

008R

I would say the same thing (apparently referring to what the doctor in the video said about the patient making the choice to come to this particular clinic instead of going straight to the cardiologist). You know, it is his choice to seek medical care where he decided first. And, I would tell him how things are normally done. We start with this and this and this ... And, I would tell him exactly what he would expect and run into, might as well.

[Question: Exactly what he would expect?] If I knew the cost, you know I would tell him what he could expect. I think people have a right to know.

I think he is a little hostile. I don't like his attitude either, but I wouldn't challenge it at this point.

011R

Again, I think the patient needs to be informed that it is not like a one time chore or a one time visit and there are conditions that require specialist health care providers and everybody works as a team. This patient is acting very ignorant to his condition and to the processes that lead to treatment.

013R

I will tell him that you came here and I am responsible for you. You came in with chest pain. I am trying to do the best for you. I am dedicated to taking care of your health. I would talk to him and try to make him calm. I would tell him that I understand that you are spending a lot of money, but I am also trying to do my best in doing my job.

014R

Basically, at this point, I guess there is basically it is the way medicine is at this point usually you see a primary care physician in the walk-in clinic. If that physician feels that the problem is something that they can take care of, then we will take care of it. And, if we feel that the problem is cardiac related and something that you need to see a specialist for, then we can refer you to the specialist, whether it be a cardiologist or a g.i. doc and then we go from there. Usually, that way it avoids people going to the wrong specialist and wasting unnecessary funds from the patient and the doctor.



**Category: Resident explains the clinic's process.**

002R

I would ask him “why he came here and not to another doctor like a cardiologist.”

I would explain to him that to get the tests done, I have to refer him to another specialist.

003R

The walk-in clinic is where we screen out all the sick people to send to the cardiologist because the cardiologist is unable to see everybody out there, he can only see the sick patient and our job is to see which one is the appropriate patient to send to the cardiologist, to the specialist.

**Category: Resident seems confrontational/dismissive.**

012R

I would definitely say, "Either you are going to calm down and listen to me or you can go see another physician."

**Category: Resident discusses patient's emotions and works with them.**

001R

"I wouldn't say anything. This is a time that calls for a careful pause. Let his frustrations be expressed completely. I can be very patient in cases like this. Some people just say, 'Time out, my turn to talk' and I'll just let him keep talking."

"I might let him walk right out of the office. No charge ... Now, when he comes back and sues me, I still have a medical record that he was in the office."

I would ask him why he is so aggravated. "Why are you angry at me?" "I think his response would be, 'I am not angry at you. I am angry at the system.' I am sorry that the system doesn't work 100% all the time, but I am still in a position to help you. I can still recommend and order the test that we feel are necessary."

I would emphasize the word "We". He would say, "You have to agree to do this test. *We* are a team to try and help *you*. It is your decision to have these tests or not"

And, I would try to diffuse the situation and make it less tense.

006R

Fortunately, I have not had many people like this.

You know, these are difficult things (speaking of working with this type of patient). Sometimes it depends on how you feel about this person.

I think in myself, I accept the fact that I am not going to be able to help everybody. You know, I am not going to be able to be the right person for that patient at any particular time. And, I can't deny that this man is obviously aggravating me at this point in time, because he's getting to be querulous.

However, I think that at this point in time, I'd still try to go over and explain why I am taking the tests, what the rationales are, and what I feel his risk factors are. I think that is a real point of fact, how serious. Again, I don't know what pain he has because it is probably chest pain again. Chest pain is a very serious thing. So, I think I wouldn't give up on him yet and explain to him how the system works, that he is part of a system and the system works this way, he has walked into this clinic for whatever his motives are, and this is how we do things.

I have options here. Like when you see someone like this, you can be just stern and defensive. You could be empathetic and sympathetic, “Yeah, I know it is expensive, what a drag.” Or, you could be quarrelsome, also.

And, you know, I do have a case where I was in the office. It was a black family that came in and they wanted me to help their father who was, he might have had pneumonia, he might have had TB, he might have had lung cancer, this and that. I was a little late getting there because I had a bunch of other things to do. And this daughter was this really quarrelsome person. I felt like no matter what I did, she was going to go call the head of the hospital (and complain). I did find that as I stood there and stood my ground and explained everything to her and as I told her, “This is the way these things happen and these are the possible results, blah blah blah.” She finally calmed down. And her father ended up being there for 2 or 3 weeks. We became the best of friends. And they came in to see me all of the time when they realized that you are under your own pressures and your own limitations as well.

So, I am not quite sure. In other words, I could take this personally and tell him, “OK, take it or leave it.”

I could realize that if he had the potential for having coronary artery disease and maybe of having a heart attack, I would hate to be responsible for him not having the proper tests. So, I could continue with this effort to keep on explaining it to him.

Or, I could, I don’t know if I would be aggressive or if I would be sympathetic or what at this point in time.

I think I would try to calm him down and continue to explain to him the system and what the risk-rewards are and what category (referring to medical condition) I think he is in and see what I can do.

009R

“You look very frustrated.” That is all I am going to say.

I would not argue. I would just let him talk. Ventilation sometimes helps.

010R

In my mind I am thinking that I need to ally with him in order to feel like we’re not working oppositionally. Next comment would probably be something to the effect of, “What would you like out of me?” Rather than saying, “This is the way it is,” I would say, “How would you like this to work?” From there then try to figure out how to help him understand how the system is.

015R

He's drawing the doctor (in the video) in. His (the doctor's) voice just came up and he tried to jump in and got defensive. That is a game I don't think you can play with especially this kind of personality. He's already irritated and angry, frustrated -- understandably, we are giving him tests that are negative for a pain that he feels.

It's hard not to do; it is hard not to strike back and get defensive whenever somebody is attacking you, saying that you're ordering these tests and conspiring against them. So, I think you have to be real careful.

As far as what I would tell him is again, reassure him that we are all working for him and that, while medicine is not perfect, we do the best we can.

## APPENDIX T

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 1B V2Q4

1. What are some themes suggestive of how resident primary care physicians respond to personality disorder-type characteristics and processes as evidenced by:

b. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/querulous type) characteristics and processes?

*Vignette 2, Question 4*

*Prompt: “If you people don’t like patients, then why do you let patients even come here?”*

**Category: Resident lets the patient vent anger and just listens.**

001R

“He would probably be pushing my buttons by now.”

I would still let him vent.

“Do I need to explain myself? I guess I would explain myself as much as necessary to try and diffuse the situation as much as possible.”

As far as what buttons are being pushed: He just keeps pushing the buttons of patience.

“I try and help him be comfortable and tell him that we will try and get to the cause of his pain and take care of him.”

I would apologize that the appointment did not happen at the time that the schedule said it would, “but it is happening now.”

“I also tell patients that I do get tied up with some patients that need a little bit more care than their 15 minute time slot will allow. And, ‘it makes me late to see you, but some

day you'll be the one who says, "Oh, by the way" and instead of spending 15 minutes with you, I'll wind up spending 30 minutes with you and somebody else will be late." Usually, patients will say that the doctor is right, but "I don't know if he will." But that is a method that I use also.

001R noted that the doctor's statement in the video of "We are getting away from the point right now" is a good statement to make.

009R

"What made you comment on that?"

010R

Again, I think I would have to stop and say ... Actually at this point I think I would ask him to vent further because what he's saying is clearly has not been anything that I have done with him. It probably does relate to something like having to wait and things like that. But, asking something on the order of, "You've been here quite a long time and that probably upset you." My style is more of I would have come in with a joke anyway, "You've been waiting forever" or "Have you been waiting long enough?" and from that I can get either an icy stare or kind of a, "Yeah, but I understand you're busy." From that I can gauge whether I am going to have a blow-up like this.

015R

He's (the doctor in the video) giving him fuel by defending himself. The physician should not have to justify the procedure. Now, if the procedure is wrong within the clinic, it is the physician's responsibility to fix it, but an explanation of why is not necessarily needed at this time.

He's upset and the best thing to do is to listen. [So, that is what you would do at this point?] I would listen to him. Say, "I understand your frustration and I know you want an answer, and I'm here to help you find that answer, but we're just not there yet."

**Category: Resident apologizes to the patient and explains the system.**

002R

I would not get “confrontational” with him.

I would say, “I’m sorry. This is a doctors’ office and things get backed-up. Sometimes these things happen and we can’t predict these things.”

004R

You know, I would say ... I would apologize first of all and say, “We try and see patients here on a timely manner. But, we can’t predict the future; we can’t always say that Mrs. Jones need exactly 15 minutes for her appointment that day. Sometimes we get behind; we do the best we can.”

005R

Obviously he is aggravated. He is switching themes. Going from his test done now to, “OK, now I’m fed up with your time schedule.” He is moving from one point to another randomly out of anger, out of aggravation. That is what I see. And then we go to the cardiologist referral, then he goes to time waiting in the office. He’s trying to find something else he can get upset at.

[Question, So do you have a comment for him?] I would probably say to the patient that I’m sorry. I’m sorry for being late. I got in late. I had a procedure to do at the patient. I calm the patient and I try to tell them, “This is not like a 15 hour oil change. You’re an individual. Some might need more time than others. Whatever, my time, I am going to give it to you as with my other patients. Some patient may take more time than usual. So, please be mindful of that. My time I give to my patients. And, if one patient needs more than another, I’ll try to compromise. I’ll take less with them. Not be mean or anything, but say, “I have people to see. Sorry, I have other patients to see and I’ll see you as soon as I can.” Make them realize that I am sorry.

013R

I would just apologize and tell him that I am very sorry. Tell him that maybe I saw a very sick patient before him or something else that may have been the reason for running late. Explain the system and that I understand he is having to pay for parking and the doctor’s visit, but we are trying to do our best to take care of him.



014R

“The problem has nothing to do with not liking patients. We want to see patients so that we can provide for their health care needs and address any issues. Occasionally, as with any person or any situation where you do not know what another patient may have, it may take a longer time, so for example if you were to have a very minor problem, it may take 5 minutes with you even though you had a 30 minute appointment. On the contrary, if you had something very serious, then I may spend 1 hour with you and that may cause me to run over and affect other patients’ appointment times. But, the point being that we provide good health care for everybody and not just make it a system where everybody gets 10 minutes of time and then they have to go out regardless of whether we have addressed what we need to address.”

[Question: So, just explain how the system works?] Kind of explain how it works and why it is sometimes that we run over when we run over and that we do apologize for taking longer because we know that their time is important as well.

**Category: Resident did not apologize, stating that the patient has a choice to leave or not to.**

003R

Well, our job is to take care of patients and sometimes when we have a lot of patients, some patients take more time than the others. So whenever we have more difficulty patients, then all of the people have to wait a little bit longer and you just have to understand that we have tried to do our best to cut down the wait time, but this is not always possible.

006R

I would not have even argued that much (referring to what the physician in the video said).

I felt that the physician's response was unnecessary. He doesn't have to make excuses for not having a definitive diagnosis.

I would apologize for being late. I think that is not polite (to be late) if you can avoid it.

But, I don't think I have to explain to him why I'm late, what is going on in my life.

007R

I would just basically say to him that, "We see a number of people here on a daily basis. Some days it could be 30 to 100 people and you may have to wait longer in certain situations because we certainly have to see every single patient. If you're upset with the timeliness of the clinic, you know it was his option for coming here."

008R

At that point, I would think that he is really going off on a tangent. "People don't like me," where did that come from?

I would at that point just ask him, does he want us to help him or would he like to get care somewhere else?

I would bring it back down to, you know, this is about his medical care and chest pain. It is his life; it is his body.

011R

Again, this is totally inappropriate. I feel that the patient is getting a little aggressive. He is not prepared at all. I think I have to re-emphasize that this is ultimately for patient care and the fact that he does have a potentially dangerous condition and if he succumbs to it, it is not only his life, but the lives of all the loved-ones around him that will be impaired or impacted. This is ultimately for the benefit of the patient. It is not to say that 100% that the patient has something dangerous.

The process needs to be broken down. The patient needs to be a little patient. There are no quick fix answers. You don't move a magic wand and cure the patient, but you need to find those answers out to help him better deal with his disability.

012R

I would say, "You are a little bit going over your limit. Let's just stop right here and end this conversation. These are my recommendations." Because, you are doomed whether you say something or not. I would just stop it right there and probably leave the room.

## APPENDIX U

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 V1Q10

2. What are some themes suggestive of resident primary care physicians' characterizations of how they establish the doctor-patient relationship when patients demonstrate personality disorder-type characteristics and processes?

*Vignette 1, Question 10*

*Prompt: What would you do to establish a working relationship with this patient?*

**Category: Resident would engage with the patient – there is a range of degree of engagement in these responses.**

003R

"I would see him more often. A lot more often than a normal patient."

"He needs the reassurances, so I would definitely schedule to see him more often than other patients."

[Question: Within those visits is there something you would do differently, a style you would take on that would be different?]

I would be more open to him and try to take down his guard, try to gain his trust. Right now he does not seem to trust anybody.

[Question: Are there certain things you would say to get him to take down that guard? What would that look like?]

I guess I could tell him that I need to see him more often so that we can develop a good, trusting relationship and if we can develop a good physician-patient relationship, then it would be good for both him and me.

[Question: So, you would bring the issues out in the open and talk about it?]

004R

I think that being available helps. But you don't want to be too available. You don't want to give him your home phone and say, "Call me at midnight" because he seems like somebody who probably would.

Long-termwise, I think seeing him more often, even though the first time you meet him you don't know if you want to see all that often. But, I think seeing him on a more regular basis and establishing more of a relationship with him, showing him that you do want to help. I think that is important.

I think getting back to him ... If he has a test one day, he is not going to be one of those patients who want to sit at home and wait a week until his next visit with you. Calling him. Asking him if it's ok if the doctor leaves a message on the answering machine about the test results. A lot of time people will send out letters [about test results] and that takes 4 or 5 days. I don't think that in his case that will be the best for his state of mind.

By introducing him to your nurse would help. So, if you're not in the office, he will be able to talk to her on the phone. Maybe she can help alleviate some of his concerns.

007R

Probably, because of this interview, I would try to have him in at least within the first 6 months every month just so that he knows that I will be there for him as far as answering questions. Because of his dependent-like personality, just reassure him every time that he comes in. Provide him with the resource that we have here as far as with social services. Sometimes, just bringing him in just to talk and see how things are going would probably do wonders for the guy. And just talking about his social situation, see what is happening in his life: does he have any questions about other problems?

[Question: Why do you think that would do wonders for him?] Well, it just seems like a loner. Like he's just isolated, worried about what people are saying about him or what is going to happen to him next and such. I just kind of got the sense that there is something going on as far as underlying ... To get to the point where I feel comfortable as far as talking with him, talking about his medical problems, to the point where he has a good relationship with me and then moving to the next step as far as bringing in a psychologist or a psychiatrist to kind of assess his mental or social situation.

009R

[You mentioned earlier some things you would do: be supportive, non-judgmental. What other things would you do to establish a working relationship with him over time?]

Probably see him regularly at the beginning.

Spend more time with him.

Educate him.

I think trust in a relationship is very important. Don't let the patient feel abandonment.

**Category: The resident's focus is on setting boundaries and referring. There may be some mention of building rapport.**

001R

Start with the next goal of information outlined for the patient. "Sit right here, I am going to get my nurse on the phone and we're going to get everything scheduled for you so you know where and when to be before you leave this office."

I would call the patient sooner if results necessitated that call or if medication is needed.

If the patient has any questions or concerns, he can call the office and leave a message and "within a few hours or a day I can get back to you."

001R agreed that there would need to be a lot of clarification and understanding.

002R

More frequent visits initially.

She would validate his complaints that have not been validated by his family.

She would address the anxiety "a little more."

She would provide some reassurance to him.

005R

I would just ask more history.

Usually if it is urgent care, you don't go that much into family history or you don't get good history. If a person comes in with a cold, you only see them once.

If a person comes in for initial care, you sit down and talk to them: social support, family history, their history, what do they do. That is where you begin a rapport with them, just asking more about them. I tell them that I am a resident and will be here for a little while, that I am from the Valley, if that is appropriate. Again, I don't want to tell them if I'm married or have any kids. I don't tell them those types of things, but I am there really for them. This is their time. I want to talk about them. Many times, people just want to talk, to share. I don't go into full detail all at once, you get little pictures. I have limited amount of time at each visit. You can't spend too much time, although you do want to.

Again, in family medicine, you can have them come back and see how they are doing, get more history and build that rapport.

006R

The one thing like I told you, I would use the age thing if it was to my benefit.

I would ... I mean relationships usually build over time as people give you more personal information about them. So, I think anybody as young as this that might be in a risk category of obviously having a coronary syndrome or even a drug abuse problem, or whatever other, or smoking history, I think it is worth my valuable time to spend a little more time with them.

008R

Make sure he's compliant with what we ask him to do: medications, exercise regiment, his medical tests, whatever he has to do.

If he is a needy patient, is he going to call me at all hours and all that? Then, tell him your office hours are this and that he cannot just pop in any time he wants. He has to call ahead of time, unless it truly is an emergency.

[Question: Establishing some boundaries?] Exactly.

010R

[You mentioned giving him extra time and reassurance, what else would you do to establish and long-term relationship with him?]

Lay down boundaries. Try to individualize those boundaries so that you can stick with him.

Probably try to expand the team. Possibly involve psychiatry or psychology or a counselor, some form of emotional ally so that it's not just the two of us against the world.

011R

Did not ask out of concern for time and it appeared she had addressed some of this in a previous question.



012R

I would probably, he might turn out to have some coronary artery disease. In this case, scenario A, where he does turn out to have that (coronary artery disease), then I'll send him to the cardiologist, I'll have him cath. (catheterized?) and after the catheterization, I'll find out whether he is going to have to go to open-heart surgery or have his artery stented and then we'll put him on the right medication and tell him to stop smoking and reassure him that he is going to be fine as long as he follows a certain diet and certain exercise, no smoking, no drinking alcohol. And, then I'll have him follow-up with me the first 6 months, every month and then every 3 months and then twice a year. And then this is how I would establish my relationship with him.

Scenario B: He does not have that (coronary artery disease), he turns out to have anxiety. I will treat him for anxiety. And, anxiety is very well treatable. I'll make sure he goes and sees a psychiatrist or a psychologist and put him on the right medication. The only reason I suggest the benzodiazepine at this point is that it is a short acting drug that acts right away on anxiety. Versus the other drugs that take 14 to 15 days to kick in. So, basically, I would probably start him on benzodiazepine and then knock it off as I am adding the other drugs which he can be on for a long term and then follow-up again on a monthly basis, then 3 months and then 6 months. And this is how I would do it.

013R

I would see him more frequently than other patients because maybe something else is wrong, not just chest pain. Maybe he has mental problems. I would see him more and get more information.

014R

The first visit I couldn't make any changes yet. If it comes down to a patient that is constantly having anxiety and basically is a hypochondriac type, then I might have to let him know that this is one of his diagnoses. That one of the things he has is this anxiety problem. It is not necessarily that I can't see him, but this is something that we have to work on together and see how far we get. If he needs additional help, then send him to a psychiatrist or a psychologist to help with that anxiousness. If he needs medications to help with that, we can do that as well. But on the first visit I probably wouldn't make a change. It would be more of a pattern that I would have to see over time.

015R

Describe the ... things like doctor-patient confidentiality. Describe the times that I will be available for him to come into my office and see me. But, he needs to make an appointment. If he needs to get me in an emergency, the way that it works ... just

describe the process: that if he calls into the office, the nurse will take a message and at the earliest convenience, I will get back to him. Or, if it sounds emergent enough, that he can go into the emergency room. That is what they are there for whenever your doctor is not available. And, on the weekends, describe coverage; saying, "I will not be available on the weekend if I am not on-call. Another physician may take care of you at that time." Just be very clear about the process of patient care.

## APPENDIX V

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 V2Q10

2. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 2, Question 10*

*Prompt: What would you do to establish a working relationship with this patient?*

**Category: The resident is willing to work with and engage the patient. Interventions range from: boundary setting; seeing patient more frequently; validating patient; establishing trust; helping patient understand the process.**

001R

Question: In addition to the empowerment mentioned earlier, if this was to be a long term patient what would you do?

Well, if we got his condition taken care of, fine [as in that is the end of the relationship].

“Personality-wise, he is always going to be one of demanding, confrontational. I don’t think he would find satisfaction with care in very many places he went to and he would wind up bouncing around various clinics anyway. In and out of emergency rooms.”

“I don’t think I would shut him out entirely.”

“Patients who are of high demand I tend to see frequently when I first meet them. Whether there is anything wrong with them or not. ‘I want you to come in and see me in 2 weeks. I want you to come back and see me every 3 weeks for the next 3 months.’ Something like that to build a stronger doctor-patient relationship and one of trust and not let them have the opportunity to say, ‘I went that doctor and I didn’t like him and I am not going to go back to his office.’”

002R

I need to “meet them half way.” I want to validate their complaint and then find out what the physical problem is.

I would ask social questions. [This consisted of family background information.]

003R

I think this would be one of the more difficult patients so that means that I would try to let him wait for too long and try to explain to him that the nature of the primary care office and I would apologize to him any time he had to wait for too long.

[Question: Is this somebody you think you can work with?]

I think I can work with him, because some people may be like this guy in the first few meetings, but eventually when the trust levels off he will just like any other patient.

[Question: What do you think for him trust is going to take?]

I have to show to him my willingness to work him.

Instead of shutting down any concern that he had, I would try to address all of the concerns in a way that he can understand and hopefully he will accept the situation. [Clarification is that he would take time to dress any concern that the patient has instead of just glossing over any complaints.]

005R

Follow-up. Make sure I do follow-up with him. If I do tests, after the tests get the results back to him. Have the results on the table for the next time I see him. Call him after the test and tell him he’s fine or if he’s not fine, set up an appointment and we’ll make it sooner if we have to.

Calling is very important to keep that rapport open, especially if it is a difficult patient. Keep communication open.

Once you do something [wrong], they go somewhere else, they go to another doctor and find one that can help them. But, if you show that you are caring and you call them, their responsive and they respect that and they come back to see you.

010R

Provide the patient with options in his care, empowering the patient. The patient needs to know what is available to him: such as options of another doctor if that personality dynamic would work better. 010R was not trying to get rid of the patient, but trying to find the best working relationship.

Not spend as much time in office visits.

012R

Probably meet with him every week on my own time without money. Take 5 minutes, 10 minutes a week just to sit down and chat with him.

[Question: With that kind of approach, what do you think that would do over time?]  
Probably show him that medicine is not all about money.

013R

I would try to see him for more appointments.

I would try to learn a little more about why he is angry. Maybe he had a bad experience with the health care system. Maybe this is just something having to do with his life right now. Maybe he lost his job and he doesn't have any money. If he has a financial issue and cannot pay for the visit, maybe we can work and get a payment plan.

014R

I would probably just ask him and say that it is important that he's comfortable with me as his physician and feels that I'm doing what is best for his health and such. Trust is an important part of the physician-patient relationship and so if he is going to constantly feel that he is not getting adequate health care after this visit or after any other visit, I would be happy to go ahead and if there is another physician he would be comfortable with I would be happy to refer him. I would like to go ahead and continue to build the relationship to see if I can help him in any way possible.

015R

I think I would just, before the end of this visit, again, you want to establish the process of medicine and make sure it's clear as far as the need for testing and the need for continued care. I would try to reinforce that since he is feeling vulnerable, that I am there to help him. And, I would definitely avoid confrontation and arguments.

**Category: Resident is not sure how to work with patient or chooses to address finances only.**

004R

He said he wanted to get the stress test done. So, the sooner the better, the cheaper the better in his case. Again, I think it's important that he get the results back ... I had something to say, but lost my train of thought. What was the question again?

[Question: What would you do to establish an effective working relationship with him? Would you have to adjust your style? Would you do anything specific to make sure y'all are on the same page together?] I think it is important with this guy to show him that you are willing to work with him in an economical way. I think he has made it clear that he is spending too much money on these tests. I think getting him in touch with a financial counselor or something like would help. If I were seeing him the next week and recommend another test, I would say, "This test as far as I know costs this much." Don't give him the chance to get angry and say, "Well how much does that cost?" Say, "It typically costs this much. Our other option is to do this test. Explain maybe it is not as good, but is less expensive or it's a better test and more expensive." That kind of stuff.

[Question: So, you think that the money issue is the crux of the matter with him?] I think it is one issue. I don't think it is *the* issue.

The next question is, what are the other issues. Again, he kind of has a sense of entitlement of, "I came in to this walk-in clinic. I should be seen as soon as I walk in. And, I don't want to pay for anything." Obviously, that makes for a difficult patient.

Maybe going in to him and asking, "Why are you getting so upset with us?" That could turn out good or it could turn out not so good. Obviously, I don't think I would do it on the first visit, but maybe if he did come back, it might show that he is willing to negotiate or work with you. So maybe you could bring that up and say, "You know, last time you seemed to be a little upset. Was it because you had to wait so long or because we wanted to more test or you felt like you were ganged up on?" That kind of depends on how he responds that second time you see him.

006R

[It took a few moments before he was able to respond.]

I think I would go back to what I originally said. I think one of the best ways, not the only way, of approaching: you know, someone can only hurt you if you let them.

And, it is very difficult to argue with someone if you are the only one arguing.

So, I think the best way to start something like this it to try to defuse it immediately. Like I would say, you bend. You sit there and let the guy burn out and let him yell and get it all out of his system and then see if he calms down after that. Especially if you are just kind of standing there.

I think you (referring to me) have someone comes into your office and is belligerent sometimes. You know, I actually have a little experience with psychiatry as being a patient back when I was a younger person. I found that sometimes these psychiatrist will sit there (he demonstrated staring) and they will listen to you, sometimes without emotion, sometimes with sympathy. And you yell and scream and when you find out you are not affecting the other person, you calm down. You get tired of screaming and not getting an argument back.

So, I think, in having tools in the tool box, that might be one of the first approaches. If I can let this person unload for 5 minutes, maybe they will finally stop screaming, because they are not listening to you anyway and then maybe you can start a reasonable conversation.

007R

Basically, you would have to explain the ground rules as far as our relationship. Certainly, define the things that I expect out of him and what he expects out of me.

Certainly, in any kind of relationship there has got to be some balance. You can't have a patient being the one that is going to just dominate the situation. But, you certainly can't have a relationship where basically your word is God as far as what is going to happen. There's got to be some balance there.

008R

I would try to, like I said, you never know, I've had some patients like that. They start off like that and end up to be some of the nicest people, they are just having a bad day.

If they continue to act like that, then I would tell him that he needs to find another physician because obviously he doesn't feel confident enough that we are providing the care that he came looking for.

[Question: If his anger continues like that, what do you think is driving that anger? What is behind it, what is the point of that? If his complaint is not valid, but this is just the way he is, what do you think the anger is about?] He either has severe financial stress and he's just not directing it in the right direction or he has no respect for the opinion of the doctor or the expert physician role.

009R

That's tough. I don't know. You can tell me!

You just do the best you can. Treat him like other patients.



## APPENDIX W

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 GQE1

2. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*General Question Extra 1*

*Prompt: “What kind of qualities do you think a primary care physician would need to work with somebody who has a personality disorder?”*

**Category: Resident suggests patience, insight AND self-awareness.**

010R

Interest in these patients.

Patience.

Insight into personality dynamics.

Self-awareness. Awareness of how one is reacting when with a patient. Referring to an earlier response when he noted that an awareness of his own emotional reaction to a patient can help him gauge how he is responding so that he does not respond out of anger, anxiety or defensiveness.

**Category: Resident stated a need to be patient, understanding and setting boundaries.**

011R

[Question: What kind of qualities do you think that a primary care physician needs to have in working with patients with personality disorders in this type of primary care setting?] First of all, understanding that the patient does have personality issues. That kind of overlies into his illness. That personality issue needs addressing. I think the approach should be guarded.

012R

[Question: What kind of qualities do you think a primary care physician needs to have to work with them in the best possible way?] Patience. That is the best thing. If you want to qualify as a family physician, patience. Your patients will come with any sort and type of question that will throw you out of the water. And, if you don't have the patience you feel just like taking that phone (referring to patients who call with questions) and hanging it up. I didn't take that much responsibility as far as calling patients because internal medicine is kind of a sub-specialty inside of family medicine. And, here, I come in and my mailbox is full of messages from patients (describing patient messages that encompasses a wide range of concerns). Family medicine is a great specialty, but a lot of doctors are worn out because you are dealing with the mom, dad, kids and the grandparents.

013R

[Question: What kind of qualities do you think a physician needs or are helpful in working with patients like this?] Doctors need to be acceptive (sic) of patients and understandable (understanding) and ... I am just trying to accept the patients the way they are.

I treat all my patients like my children.

013R also mentioned that she tries not to take the behavior of her patients personally, that she recognizes that something is wrong with them, "with their brain", and not to take things personally.

014R

[Question: What kind of qualities do you think a primary care physician needs in working with these patients? They can range from being hostile to weak and helpless. What kind of qualities would you need as a physician?] I guess patience would be the first thing; a lot of patience. I think that is key because with patience you can listen to what they are saying. You can't be very abrupt and quick. You need to, you can learn a lot from what somebody is saying to you, you have to take whatever time it takes, that is key.

Second is I guess and understanding of being a good communicator both ways: understanding what they are communicating verbally and nonverbally and then you need to communicate to them as they need to be communicated to. Those are key.

And then the obvious one, understanding of the psychiatric and physical problems so that you can differentiate one from the other and treat it accordingly.

[You mentioned understanding their verbal and nonverbal communication, could you say more about what their nonverbals would be?] First thing is posture: is somebody coming into a room and slouching, or their standing like this, or completely guarded (sat with arms crossed). Second is eye contact will tell you a lot. Eye movement will tell you a lot. Fidgety in eye contact. Third is their hands and legs in terms in of how they use their hands. The other is what they are wearing or what they may be, what they look like in terms of their hygiene, whether they come in smelling terrible and whether you need to address this as a health issue or whether they come in very neatly done up in terms of if everything is perfect. I guess those are some of the physical or nonverbal things I would look for.

015R

[Question: What kind of qualities do you think a primary care physician would need to work with somebody who is borderline or has a personality disorder?] They need to be professional. They need to understand the disorder, to understand the need for boundaries. To not get offended, to be thick skinned. To not play into their personality type: if they try to bait you, then you don't bite.

## APPENDIX X

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 2 GQE2

2. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*General Question Extra 2*

*Prompt: "When you realize that you have a patient with a PD, does that change how you conceptualize the patient and treatment?"*

**Category: Resident would change how she/he communicates with the patient.**

003R

[Question: When you get the recognition that somebody is borderline or histrionic, does that change for you your long-term approach with them, change how you are conceptualizing your relationship with them?]

It does; it changes the way I approach the patient.

[Question: We've talked about more frequent visits or addressing the issues, is there anything else that that would change for you at that time?]

First, I would be more careful. [Question: What do you mean 'more careful'?] If Histrionic or Borderline, I have to make sure that I would see the patient with somebody near by, don't try to be alone with that person.

[Question: Does knowing about the personality disorder, change your thoughts about what they are presenting with, their physical complaints? Does it make you question whether or not they are somatizing?]

It does. I think that maybe there is another component in this heart problem. Maybe some anxiety component.

006R

1a. When you realize that a patient doesn't change over time and you get the idea that the person has a personality disorder, how does that change your conceptualization of the patient and change your treatment approach with a patient?

First of all, I think there is a little problem with the psychological labeling. I don't think anybody is one category. They are usually a combination of ... Although, it is true, some people certainly have a tendency to be self-centered and unfeeling with their statements, etcetera. I guess, if I did feel that this person did have that predisposition and they are already labeled as such, I don't think it would affect my medical decision making, but it would probably affect the way I decide how to approach them. In what way, I am really not sure. I wish I could give you a direct answer. I am really not sure.

Most people come to you because they are looking to solve a problem. I think with someone like that, you have to sort of define the rules possibly. I think with someone like that you have to say, "Look, you're here for this and this." As you slowly build a rapport with them, I think you need to say, "You know, this is what you are here for today. We'll see how we can solve this." I we'll see if he decides to continue to come back.

So, I don't think it would affect my medical decision making, but I certainly talk differently to a grandmother than to a kid.

So, I think with someone like that, you have to be much more didactic. I think you have to set up rules at the beginning of the encounter as to what you will do in this encounter and what they can expect so that there is no misunderstanding.

007R

1a. [Question: When you realize you are dealing with a patient with a difficult personality, how does that influence your conceptualization of the patient and conceptualization of how you are going to treat the patient? What changes?] Everything changes. The way you interact with him. The way you explain the way things are going to happen.

For example, with the first person, he seemed like a very dependent person who probably needed more time to at least basically, carefully telling him step 1 through step 10. You may just have to write out what is going to happen and give him all the expectations that he may need.

Second person, he's a very argumentative, overbearing person. Certainly, you are going to have to deal with him a little bit differently as opposed to the first person. He probably doesn't want to hear the details. He just wants to hear what is going to happen, period.

Different personalities, you're going to have to deal with them differently.

010R

"It changes the options that I can use."

A BPD female near my age equals danger. He said that the boundaries in this situation are too hard to maintain.

He also noted that, "I won't do well with some personalities."

011R

[Question: When you have a patient with a personality disorder, with ASP or BPD or those types of disorders, how does that work into how you conceptualize the patient, go about treating that patient?] For me, it does have a big impact on how I approach the patient because I think that makes a big difference as far as impact whatever approach I take towards managing that patient. How I approach him will impact how he will comply to what I tell him as far as treatment and management go. I am a little more, if I have to be with someone who is antisocial or has a severe personality disorder, then obviously I am a little on guard and careful as far as my choice of words. [Question: What are you guarded against?] I would say (guarded) against anything that would set the patient off or trigger him into a negative mood.

012R

[Question: When you realize that you have a patient with a personality disorder like BPD or ASP, does that change your conceptualization of what the physical problems might be? Whether or not they might be somatizing?] Definitely. When you have a patient who comes in ... let me give you a scenario: Patient comes in and is a fairly young guy, 24 year-old comes in and says, "Doc, I was told in the past that I had a murmur." I said, "How old were you?" He said, "About 2 or 3 years old. Now, I am a little concerned about it, but if you don't think it is a big deal, that's fine." I listen to his heart and he does not have a murmur. I explain to him that kids sometimes at a younger age have a murmur, but if it goes away, it goes away and there is no need for further assessment or further evaluation. "Alright, doc, I trust you." He never asks me another question. This is a patient who trusts you completely.

Let's say this patient says, "What if it shows up in 2 years again?" or "What if I have chest pain suddenly, do you think that it is from it (the murmur)?" He starts asking me questions. This is a patient that is basically hypochondriac or had some type of personality disorder. But, you are going to have to pay attention a little bit more because anything that happens to him is going to be a big deal, such as an ant bite or has a

headache with eye hearing. Of course you are going to pay a little more attention and more reassurance.

With the first patient, you won't see him again in your clinic for the heart murmur. This patient will never go to another doctor and say, "I have a heart murmur" because I told him he doesn't have it anymore. So, that won't be on his agenda anymore.

A patient with personality disorder, you tell him, "You don't have it (the murmur)", he keeps it on the agenda when he sees another doctor.

That is the difference: you start knocking off problems, but they (the patients) are not. They go to another doctor with lists of things.

[Question: What do you think is motivating them?] Well, the reasons are: some want attention, they don't get attention. Some of them are not sure or don't trust their doctors. Some are very, very convinced that they have the disease and no matter what the doctor says, "I (the patient) still have it", but they don't have any evidence that they have it.

I used to have patients at LBJ, homeless and the reason they would come into the hospital is to be touched: for us to palpate the lymph nodes in the neck and you could see the patient close his eyes because somebody is touching them. And, we would do the exam and we will touch them just so that they feel good and then we'll discharge them. But, that is the only reason that they came to the hospital. They have nothing wrong with them. They've come up with something; they just want to be touched. Because, on the street, who is going to touch you? Your hair is full of ticks and you smell, who is going to come and shake your hand? The doctor would in the hospital and would feel for you lymph nodes in your neck, in your abdomen, everywhere.

[Question: With those patients, did you try to work with them more directly about those needs?] Well, some patients, you know working with them on their needs is very, very useless. Such patients who came to LBJ to be touched are basically alcoholic. They've already doomed themselves to die under the bridge. There is nothing you can do for them. You send them for help. They usually make good money under the bridge and they buy beer with it. They tell you that, "How many beers did you drink today?" and they tell you, "24." "Well, how do you afford that?" "Panhandling." So, they make good money; they are happy there. Those people are very hard to work with.

But, somebody who comes in who is very obsessed with their diseases, I believe psychiatry does a much better job than me. Send them to a psychologist rather than a psychiatrist because psychiatrist usually pinpoint the problem and the chemotherapy treatment for it. But, a psychologist kind of digs back in your past and I don't have the capacity for doing that.

013R

[Question: If you realize that you have a patient who has a personality disorder like borderline personality disorder, does that change the way you conceptualize what their issues or how you treat them?] Will you repeat the question. [Say you have a patient who has chest pain but you also realize he has BPD, does that change the way you conceptualize the patient, treatment, your relationship with them?] No.

014R

[Question: Let's say that you do have somebody you find has a personality disorder, let's say BPD, does that change your conceptualization of their illness or your treatment with them?] Treatment-wise, it doesn't change the tests run, but it does change a little bit how I communicate because there are different types of people. Some people I feel need 15 minutes to know what is going on in terms of them being comfortable. Another person might need a 2 minute explanation and they have a grasp of what I am going to do. Basically it will differentiate on how I communicate what I'm doing and why I'm doing it to make them more comfortable.

And then, if I need to, also to get more information about why their personality is the way it is. And then treat it of course, if I need to treat it like behavioral, are there things we need to talk about, are there issues where they need to see a psychologist or a psychiatrist or is it something that I can treat on my own just talking with a patient, doing therapy with a patient on my own.

015R

[Question: Once you realize that you have somebody like this, somebody who is borderline, does that change your treatment approach or your conceptualization of the patient?] I would be more strict with the patient. I mean, not necessarily be as ... I would watch my signals. You know, normal patients like I was saying, you could come into a room and put your hand their shoulder and talk to them about this or that; somebody with a personality disorder may occasionally see cues or pick up on things that on you are innocent, but by them meant something. And so you do have to keep it a more professional atmosphere. Sometimes you get into that situation where you started out just as you would with anybody else, being very friendly and then you realize that something is not quite right with the way they are responding to me and you have to adjust, slow down and you have to reiterate your boundaries and exactly what this relationship is going to be like.

[Especially with the first person, let say this person turns out to be borderline, they present and they are very aggrandizing of you and your ability and power, and that can feel pretty good, that you are their cure-all. And, that comes at a cost. Later on,



sometimes with borderlines, there could be a pretty quick switch I would think.] Yeah, they immediately switch over. And, you're not there to have your ego stroked. You need to do whatever is best for the patient and sometimes that means being harsh and say, "You need to get off your butt and go do this." At all times you should keep in your head if this is good for them. You have to think if you're treating the patient or treating the physician.

**Category: The resident would question the patient's physical complaints and suspect some alternative non-physical reason for the physical complaints.**

004R

[Question: You said something a second ago about kind of using that information to determine how you are going to work with them. Explain to me a little bit more about that. Are you saying that if you know you have somebody who is borderline, that is going to factor into your overall treatment conceptualization with them?]

Well, yes and no. More so kind of how you are going to interact with them. I am not sure how to word it. I guess if patient A comes in and you have been seeing her for a number of years and you know her not to have a personality disorder and she comes up with a new complaint, you are might take that just at face value. Whereas patient B has some histrionic features and they come up with a new symptom or something that is starting to bug them, I think in the back of your mind you're not as apt to take them at face value. Whether that is good or bad depends on the situation.

[Question: Not taking them at face value because...?] Not taking them at face value because in the back of your mind you know this person has a personality disorder. Depending on the disorder they have, maybe they are making it up or it is not that bad or ... I don't know. I am talking in real generalities here.

[Question: Something else might be going on here than what the actual complaint is?] Right. Some other kind of psychological or psychiatric problem might be going on.

005R

1a. Does the presence of something like Borderline Personality Disorder change how you conceptualize the patient or how you treat them yourself?

I would usually ask more question. If someone has a Panic Disorder or Anxiety Disorder, you have to ask more questions: what is pain? Again, the quality, when does it come on?

How does the person with a personality disorder or panic disorder or anxiety disorder will have to ... these people [doctors] will say, "Well, I know she has a known disease, so I'm not going to work her up." That is when you have to get the good history. 005R went on to describe how he would ask more questions about the pain/symptoms (i.e., when does it occur, where is it felt, etc...)

If people come in with chest pain with all the other symptoms and it not be cardiac is very rare. [005R is stating that if the person is detailed in describing symptoms, then most likely he/she is truly experiencing a somatic problem. However, if symptoms are vague, then there may be other personality-related issues involved. There may be a physical problems, but something else may be occurring.]

008R

[Question: When somebody has this type of personality disorder, does it change how you conceptualize treatment with them? How you are going to work with them? Do you think they are somatisizing or not?] Yeah. You have to take into consideration whether they when they come to you are they really telling you the facts or are they looking for something else. You have to look at if see if they are non-compliant, then why do they keep coming? Why do they bother? They are obviously not concerned about it, they are not doing anything to help themselves. [Question: Do you think there would be anything behind that?] Sometime they are looking for workers' comp. Sometime they need some sort of excuse for the insurance company. Or, they want somebody to feel sorry for them in some way or another.

## APPENDIX Y

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 V1Q6

3. What are some themes suggestive of how resident primary care physicians' characterize their reactions to patients with personality disorder-type characteristics and processes?

*Vignette 1, Question 6*

*Prompt: What is your overall reaction to this patient?*

**Category: Resident recognizes patient dynamics of dependence or of anxiety and identifies his/her own reaction to the patient.**

001R

"If he walked into my office, I wouldn't let him go out with that look on his face."

"I am not going to be his best friend, but I would like him to know that I am not going to keep him at arm's length either."

001R agreed that there is a nice middle ground. "Maybe that is the fault of a family physician." "Sometimes in wanting to care for patients, they will look up your name in the phone book and call you at home if your listed and they will expect care that kind of goes beyond the professional level and it's only a brief lapse in the doctor-patient relationship, but I think that it happens more to family practitioners than others."

The cause of this is, that the well-rounded family physician has just as much concern about the patient's psychosocial issues of the patient than any internist would. 001R seems to suggest that the family physician is more sensitive to psychosocial issues than the internist.

003R

I am surprised by the patient.

It seemed like he had some anxiety.

He seems to be overreactive with the simple test.

It may be that I did not explain enough to him about the nature of the test.

010R

My reaction is a sense of: first, if it's a busy day, I would be annoyed by it because I would slow down with this patient and I'll be a lot later than if I didn't have to slow down for him.

But, my sense is that there is an unlikely large cardiac component to the pain. Most likely, high anxiety component to it. When I say component, though, rarely do you get truly a complete psychiatric pain or a complete organic pain. So, he's feeling something, but I have a tendency to lean towards: this is more likely anxiety pain.

This particular patient is going to some time and reassurance. Frequent visits to meet what he needs.

012R

This is how I interact with all my patients. I'm probably a bit more empathetic than other physicians. Somebody like that, he showed me symptoms of anxiety and nervousness. I would tend to not probably give them all their needs, but at least some of their needs because this is kind of dangerous for somebody who is that anxious, that worried, to go home and let him just fret by himself. Especially somebody who is totally saying, "Can I call you anytime?" Those are signs of anxiety/depression/dependence. That kind of patient would be very, very worrisome to me. I want to make sure that they go home and that they're safe. I wouldn't send this patient home by himself; I'd make sure that there is a family member going (with him)."

[Question: When you say "his needs", how would you characterize what his needs are?"] He wants something to relax, which is completely understandable. This is a patient who is 44 years old, has a family history of coronary artery disease such as heart attacks, he's a heavy smoker, and those are two major risk factors. Being a male, just being a male, is a risk factor, especially at age 44. So, I'm not completely going to deny his symptoms or deny even that the physical exam is normal and the electrocardiogram is normal, most likely he will show something on a stress test. He probably has anxiety too. But, I'm not going to adjust, or the fact that I see signs of anxiety in front of me as somebody who is completely concerned, I'm not just going to drop all of the risk factors: this is a patient who is really concerned. Of course, I don't have knowledge of how much drugs he does. I don't know any of this. I am judging on a person who is probably not doing cocaine, is not taking a lot of drugs, I would definitely give him a small dose of the antianxiety drugs, make sure that he has a family member at home.

013R

He is a little bit annoying. He takes more time than I need to spend with him. It would cause less time with other patients. I would still take my time and do my best.

I would maybe give him medicine for anxiety.

He looks like he just needs somebody to talk to him. Sometimes patients are just looking for attention. I think I would spend a little bit more time with him.

015R

Very concerned. My reaction to him? [Yes.] I am obviously concerned about the patient. He seems very nervous and sensitive to his own physical state. And his demands on his physician, I think there needs to be a clarification of the doctor-patient relationship. He seems to be very dependent on the doctor: he wants to have him there at the stress test; he doesn't want to be seen by the ER doctor, he wants to be seen by him (the doctor). I think some discussion of boundaries are needed.

**Category: Resident identifies patient dynamics (i.e., anxiety), but not his/her own reaction to the patient.**

002R

He is a difficult patient.

He is a dependent and anxious patient.

He seems like somebody with a lot of underlying psychiatric issues.

I don't want to discount the chest pain, but there seems to be something else going on with the anxiety.

002R stated that she may try to address the physical and psychiatric issues at the same time. She would address the psychiatric concerns by trying to identify why he is worried. For example, she would inquire as to whether someone he knows or a family member recently had similar medical problems and that this may be the cause of his anxiety.

004R

"He's probably not the most easy patient to deal with, but certainly not an atypical patient."

A lot of patients want an answer right away. They don't want a differential diagnosis. They want to know *what* it is. Unfortunately, a lot of times we can't give them a specific diagnosis right there on the spot. It is why we have to order tests and have them come back and go over those tests with them.

"Obviously, he seems to be a lot more on the anxious side. I think his anxiety is certainly playing into it."

[Question: "Playing into it", how is that?"] I think he will have this chest pain and possibly he gets anxious about that or that kind of worries him, so that doesn't make the chest pain any better.

[Question: You said he wasn't the "easiest patient to deal with." Expand on that."] You want patients to ask questions and you try to give them a straight answer. But a lot of times you can't. This patient seems to ... he's kind of ... maybe he's acting a little bit entitled because he wants his doctor to be there 24 hours a day "If I [patient] call the ER, will you [doctor] come to the ER?" So, maybe talking to him some more about exactly

how doctors work out the call schedule and stuff like that and reassure him that ER doctors see chest pain just as much as we do might help relieve some of his anxiousness.

[Note that he did not seem to give a personal reaction to the patient, but gave more of his observations of the patient.]

005R

Thus far, the reaction is: here is a gentleman who comes in and is a little bit anxious. He is wanting something to be done. From what I hear, he is agreeable for a chest pain work-up. He asks questions about the pain, making sure the doctor is there, making sure that he is comfortable with his surroundings. He is obviously comfortable with you as a doctor because he is asking, "Are you going to be there? Are you going to be there? Are you going to be there? And, How can I get a hold of you?" He needs a lot of reassurance and education on what is going to be done on him.

Other thoughts on him, I would just see where else I can be investigating, not just cardiac. Is this just a symptom of an underlying problem like an emotional problem, anxiety, panic attack, that type of thing as well?

The things I think about his, what is the worst thing that I have to make sure it is not. What can he be dying of right at this point? Certainly, not panic attacks or anxiety, not really. The cardiac we have to rule-out, esophageal, g.i. problems, stuff like that.

[Question: You mentioned the cardiac pain as a symptom of underlying emotional problems. How would you explore that?] Well, I would just ask him, "Do you get this chest pain when you are angry or you're emotionally heightened? When do these pains come on?" Again, you ask all of these questions anyway when a person comes in with chest pain. 005R proceeded to again review the questions of when, where, precursors to the pain. It is hard to know if we should be turning away from just cardiac to more underlying emotional or panic attacks or anxiety attacks that could be triggering the chest pain. Again, history is very important and I don't have much history, so I would want more history. Let's say he has no family history of chest pain, lipids are good, he doesn't smoke, he is active, he's a young guy in perfect shape who is having chest pain sometimes. As a doctor you have to investigate and see where those things are. Cardiac, it is possible, but not probable for him to have a heart attack at this point. It could be reflux. People can have chest pain with anxiety. Emotionally, that is where I investigate: you sort of test the waters and see where it is positive and just go down the avenues.

006R

Number 1, My overall reaction is the first thing you should be concerned with is anything that lead to mortality. So, I am concerned one to assure myself that he does not have



coronary artery disease. He obviously did have risk factors. So that is my one thing; I feel like I need to eliminate that.

I would put him in a category in my head that I would be a little concerned about drug seeking behavior because of his age group and his response. But, I still wouldn't label him at this point in time.

And I probably at this time might even prescribe a little mild sedative or whatever to see if it would help his anxiety. I don't feel like I need to label him at this time, because I don't really know for sure. But in my mind he is in a suspicious category.

"I think at this time, too, I guess I am an empathetic person, I would reassure him that I would try my best to be there to accompany him."

And, as I mentioned earlier, to reiterate what are the signs and symptoms of coronary syndrome; that he needs to go to the ER if this or that happens.

I think I would also ... You know, I didn't get enough information here. I feel that there is not information here to make a full ... Obviously, the history and physical is taken before, so there is more social information about this person that I don't know.

007R

Well, we see a lot of people like this as far as different types of personalities.

Certainly, this guy probably has an underlying personality disorder. Whether it is related to his education. Whether he has had previous problems with other people, whether it be work-related or at home. And, he has been through difficult times and he's now having either panic disorder associated with this personality or whether he is having true cardiac pain.

Certainly, this is atypical chest pain in reference to cardiac.

Certainly, this is probably more of a psych issue, but that is not to say that I not had people who have presented with severe depression and end up having severe coronary artery disease.

[So, they have both?] Right. In fact, on interesting case, I didn't blow it off as an atypical chest pain, but we placed him in the hospital that day just because he had risk factors. He was a previous smoker. He had strong family history, but within the past year, he basically his accountant was stealing money from him. He lost over \$80,000. And, I think his wife had cancer. So, he was depressed, but certainly he ended up having a block of a main artery.

After those experiences in the past, you certainly don't want to rule that out, especially if there are strong risk factors.

[Question: You've used the term 'personality disorder,' what does that mean to you?] The way that people interact with certain people. They may have a different affect or mood with that, whether they're very aggressive type person, or whether they feel kind of isolated. Those several different terms of the DSM-IV: the schizotypal, the [schizoaffective?] schizoaffective types and so forth.

But, that is not to say that ... I don't know much about his past social history: his education level, his past personal problems and so forth. Certainly, that may have an effect. Or, has he been in a traumatic relationship? Or, some kind of post-traumatic stress disorder to make him feel uneasy in an enclosed environment or just dealing with different people?

008R

He seems anxious. This is the first time this has ever happened to him.

He only knows as much as the doctor tells him about his illness.

[Question: So, what do you mean by that?] He has no idea about what his current status is. He doesn't know what is going to happen to him. He is anxious about the pain. If nobody is around, can he call somebody. And, so far the doctor has only told him, "Well, I don't know what it is yet."

[Question: You would try to give him more information?] I would definitely give him more information about what could cause the chest pain, and, from the symptoms that he had and why we're doing the test.

[Question: And, you're hoping that by giving him more information, you are going to alleviate some of his anxiety?] Definitely. Especially giving him information about where to call and who to call if he has pain. He's anxious about if he calls the ER, he'll have to start all over from scratch again.

009R

I think this patient's chest pain is more anxiety-related. Even though he has a lot of risk factors, we have to do the stress test to rule-out cardiac etiology. However, the anxiety could have aggravated his chest pain.

I think we need to probe into more his social stressors.

He is very insecure. He probably has some type of borderline personality or some personality problems.

[Question: What is it specifically about him that is making you lean towards the anxiety as having a role in this rather than straight cardiac chest pain?] During the whole conversation, the patient is very stressed: looks stressed, nervous, sweat, and he's very insecure.

011R

The current interview? The physician's overall reaction? [What would be *your* reaction to this patient? How do you react to him personally?] I don't understand the question. [If this was a patient of yours and you just had an interaction with him, would you say that you had any type of an emotional reaction to him? Did anything go off for you as far as an emotional response or reaction to him?] No. I guess with all patients the connection is strictly professional. This is a very common scenario that we see on a regular basis.

[So, your personal response to a patient does not come into play as far as working with him or her? Is that what you're saying?] Yes. I try to keep my visits very professional and, obviously, it depends on different patients: some patients are more anxious than other; some patients needs to be informed more; and then you also consider if you have a mother with a pediatric case, then the way you approach the patient is totally different versus if you have on the other spectrum an patient with an elderly patient. The other thing I as a family practice resident have learned as far as my approach to the patient every time I initiate an encounter, globally I am thinking of the patient as a whole: his mental framework and his physical ailments. That is what is so unique about our family practice is that we are not told to divide the patient into different specialist sections. We look at the patient globally. So, that is how my approach generally is.

[So, based on that you adjust your style?] Yes. [So, with an anxious patient, how would you characterize how you would adjust your personal style?] The first thing is that I would not feed into his anxiety. From a professional perspective, I would be direct, I would ask open-ended questions, and I feel that I would provide him with complete information which is complete and concise. I would not like to give him a false sense of reassurance, but for now, "I don't know what is wrong with you and your physical exam was normal" because those (statements) may give the patient a false sense of security and he would misperceive the concept of further testing. I would be direct, I would be open, I would not be emotional and I would provide him with adequate information.

014R

He seems a bit anxious in terms of symptoms and even his physical mannerisms and such, a little fidgety. He also seems that apparently ... like when he asks about the

medication it is like, "I'm not trying to get any medication or anything out of you." Apparently, at one point he may have been accused of this before. It is a possibility that someone either didn't take him seriously or he has had problems with it in the past, one or the other. Not knowing any history, that is just a thought.

## APPENDIX Z

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 V1Q7

3. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 1, Question 7*

*Prompt: What kind of feelings did this patient evoke in you?*

**Category: Resident identifies some personal reaction to the patient (some understand the importance of the relationship).**

001R

“He is anxious. He makes me anxious in his body language.”

001R indicated that he had his medical education overseas and is a little more in tune with reading body language because of that.

001R feels that the patient’s body language indicates that he is “wound-up, anxious, concerned about his health and now he is concerned that he is going to have a heart attack when it may not be his heart at all. It needs to be looked into.”

001R feels that the patient’s family is not believing him, he thought his doctor believed him, but now his doctor is giving him the brush off. He still feels like an outsider and alone, ‘nobody is paying attention to me.’

It might be cardiac in origin or g.i. in origin, but there might be an anxiety or psychological part too.

004R

I mean, there are always first impressions. I mentioned that when I saw him that at the beginning he had a real flat affect. I don’t know if that is because he is a poor actor or that is how he was supposed to be acting.

So, your first impression is that this is kind of a young guy, appears anxious, and that is probably what I would be leaning towards: anxiety is causing his chest pain.

[Question: Would it draw from you a response of did you feel angry with him or frustrated?] I wouldn't say angry. Frustrated would be, I was kind of getting to the frustrated point. Of course that depends on how many other patients I have to see that afternoon. If he is my last patient and I don't have 3 other patients waiting, that definitely can contribute to how frustrated you get with some patients. He seemed to be on the needy side. If you have the time and you can explain some things to him, sometimes that helps. But, with a lot of patients that just leads to more questions and more anxiety.

005R

Well, um [005R folded his arms and seemed to be guarded in how he responded. It took several seconds before he responded.] I don't know. I mean ... That is a good question. It was not that I felt sorry for him or angry towards him. The one thing that I, why did you ask me for medicine for this thing? Again, what kind of medicine do you want. Again, if they say, "I want Demoral or Vicodin." Then you say, "Oh no, not another one." 005R then discussed how he would pursue discussing the types of medicine the patient has taken and whether he has taken any drugs. But, again you only have 15 minutes so you have to prioritize your investigation. You could spend all day with a person like this. You have to say, "Today at this visit I have to take care of this. I'll see you in 2 weeks and we'll what is working and we'll be able to address some other problems. In the meantime, we'll see how this is going."

[Question: Sort of one piece of the puzzle at a time?] You have to. With a person like this who has a lot of problems, you have to sort of test the waters initially and see what is abnormal and you have to work up each one as possible. That is the beauty of a clinic, you can see him in a week or week and a half and see how he is doing. "If you are doing worse, come on in, but if you are stable, we'll see you in a week and a half." Most people will say, "OK, I have a doctor looking after me. I have a safety I can fall back and he'll be there in case I need anything." Most people need reassurance that they are not going to die today. They know there is a cause for their pain and that relieves their anxiety.

[You're taking away the unknown?] Exactly. You're not going to cure them, but at least you're saying, "OK, if it is bad, I am going to tell you it is bad. If it is good, then great." "But at least you are going to know something. If I don't know, then you don't know. Whatever I know, I am going to try to explain to you what we are thinking" And then give them the options to go down. It is all about patient education and that rapport you have with them. If the rapport is not there then ... That is the one thing I love about family medicine is getting that rapport. The rapport is what keeps them coming back because you can talk to them and ask them what is going on. Instead, you are making

them part of the solution, not just they come over to see you and you are the solution, but “you are part of the solution also, patient.”

[Empowering the patient] Exactly.

006R

Yeah, I did. I felt when he was defensive about being labeled as a drug seeker, I think that does make you feel a little suspicious for sure.

[Question: Could you characterize any other emotional response that you might have to him?] Emotionally or intellectually? [Well, whatever you think is more appropriate for yourself. Are your reactions to patients more cognitive/cerebral or are they visceral and emotional?] Well, you know they are both. Different people can illicit different things in you.

“Now, this is a 44 year old something and I am a 54 year old person. I could relate in some ways to him and I have done things in my past that affect my health. I feel that it would be worth spending a little time with him talking about some of the risk factor categories. I definitely would try to explain to him (you know, back when I was a kid, everyone smoked) the present knowledge of how socially we kind of create our own morbidity. Does that make sense to you? [Yes.] And, I think being that, I am kind of in a similar age group with this person, I think it would be worth my time to speak and illicit a little more about his history. I am concerned about him.”

[Question: Can you say a little more about how the age is affecting that? Given whether you were 20 years further down the road or 30 years prior, why does the age similarity seem to tap into that a little bit more than not? (Here, I am trying to get at whether his awareness of their similar ages is tapping into his own feelings related to coronary disease and health concerns.)] I think in some ways, you can socially relate to what somebody might have experienced with certain age groups. How more specific do you want that? [Whatever you say is fine. I was just trying to tease that out a little bit. As opposed to if you were 34, are you saying that you don’t think you would explore those risk factors as much because you don’t have that similar experience?] I am not sure. That part I’m not sure. The risk factors I think I would always explore because, you know, due to my experience, whether I was 34 or 54; however, his age group, which is maybe closer to mine, I could see some ... You know, frequently patients would come in to me in their 50’s and I would use myself as somewhat of a model. Here I am 54 years old going in to a residency program. It is kind of unusual; there are not that many people doing it. A lot of people come in in their 50’s or late 40’s with depression, maybe they have made mistakes in their life in the past, maybe have ... there is a whole gamut of ways people live their lives and if I could use myself of some way of relating to them and affecting them, I see that as good a tool as anything.

If someone comes in and they are having the potential of coronary syndrome, drug abuse, this and that, and I can say, “Hey, I’ve lived through that; I’ve done these things, I’ve made those mistakes and, you know, here is how I feel about it.” I can see that as just be as useful a tool to be relating to someone. You know, relating is a good thing. [A tool.] Yeah, a tool.

010R

Sympathy and annoyance.

(010R went on to describe 3 patients he has that are similar to the one in this vignette.)

012R

“Definitely (had an emotional response to him).” [Question: How would you characterize that?] By him being dependent on me. That is, he doesn’t have anybody to depend on.

[Question: How do you respond to that kind of dependency?] I would try to help as much as I can. This is a patient who is completely trusting his physician and wanted his physician to be there. And if this physician could be there and did not show up, that is not a good physician. You want to work on your trust. Trust is something you work on, but it is not something you gain or you are given on a gold platter. You have to work on your trust. If you don’t show trust to your patients, you don’t deserve them.



**Category: Resident indicates no stated emotional reaction to the patient (distancing).**

002R

I knew he was going to be difficult.

I knew he would not be routine.

He needs a lot of reassurance and counseling.

The patient created some anxiety for 002R. The anxiety was related to her sense of a “lack of experience” in working with dealing with these kinds of physical problems. She felt that increased knowledge and skill in addressing the patient’s physical problems would alleviate some of her own anxiety. [Note that she did not include lack of experience in working with the personality issues.]

003R

[When I asked 003R this question, he asked me to explain what I meant. It seemed that he did not understand what would be meant by his having an emotional response to the patient.]

I wouldn’t be mad at him, but I think that he needs a little more attention and I should spend a little bit more time with him to explain to him and hope to calm him down.

Apparently there is some anxiety component here and he probably has a good reason to have the anxiety because he has never had this [testing] done before and if he has some underlying psychiatric component any new thing would bring it out. [The medical condition] is “bringing out his personality” style.

007R

“What do you mean by emotional response?” Did I feel sorry for the guy?

[There is a whole range: mad, happy, sad, feel sorry for him. Did anything come up for you?] No.

008R

[Question added to end of question #7: Did it bring up anything for you?] “No.”

009R

From me or from the doctor on the video? [From you specifically.]

I don't see any reason. I think that the uncertainty of the chest pain may be making him more nervous. [Question: Making you nervous?] Making him (the patient) nervous.

[Question: What about you; did you have any reaction to the patient?] A lot of times those type patients sometimes, put some stress on the physician, too. It is kind of a demanding patient, this type.

I guess sometimes you have to be non-judgmental and more supportive to them.

011R

[See number 6.]

I would be direct, I would be open, I would not be emotional and I would provide him with adequate information.

013R

None.

He is annoying to me. Maybe not annoying, maybe it is just that he is disturbing my schedule and I would be a little bit worried about my schedule: maybe I already have 2 other patients waiting for me. He is not annoying; he is just disturbing a little bit.

014R

None. Not anything that comes to mind.

015R

I felt like he was a little somatic, just very sensitive to his own sensations.

[But you wouldn't say that you had any type of ... you weren't feeling angry or sad or ...?] I don't dislike him at this point. I feel like I would need to discuss the boundaries

because I think that it would get to that point. He seems like a very demanding patient that if I don't keep the doctor-patient relationship strict, then he could become very dependent and intrusive.

## APPENDIX AA

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 V2Q6

3. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 2, Question 6*

*Prompt: What is your overall reaction to this patient?*

**Category: Resident is able to state his/her own personal reaction to the patient.**

006R

No one likes to have a belligerent patient.

I am aware that there are all kinds of personalities in this world.

You have to learn that there is going to be a subset of people that are going to behave this way. And I think you have to learn to deal with them.

I am not 100% sure that I have that skill yet. But I would like to think there would be a way I could defuse someone like that.

I think you need to be pre-prepared for someone like this. [Question: What do you mean?] Meaning that anytime someone is confrontational, if you don't emotionally know that you are going to meet a certain percentage of people that are confrontational, you might become, you might react in the same manner. But, if you know in advance that there is going to be a certain percentage of people that are going to react this way and there is maybe one or two little tricks to defuse them, it's nice to know that in the back of your head. It's kind of like knowing that if you are working in the ER, you have to know what to do if someone comes in with an MI and you got to know in advance how you are going to behave.

So, I think that in the case of something like this, I think you have to almost academically face the problem by having a plan of action before hand.

010R

Unappreciated.

Annoyed.

010R said that if he is not too tired, then he is able to be more understanding of the patient.

012R

Of course, I would be very, very angry. And, I've had patients like that.

But, this is very hurtful and harmful to the physician. The reason is that most doctors don't make money from these patients. Patients have the idea that doctors are making a lot of money from sending them for this and that. This is completely untrue and that hurts us deep inside. This is a situation where the patient chooses to come to you and seek your help and then you end up getting a scolding from them. That is kind of ridiculous.

014R

I guess I'm a bit surprised. I guess my defense mechanism is kind of a smile or laugh. That is how I react to different types of responses from people. So, regardless of whether they are aggressive or real passive or moderate. I'm a little surprised. I guess I've seen it before in terms of I've heard people get upset about waiting and I've heard people get upset about unnecessary tests. They have a right to be upset after waiting 2 hours, understandably so. Sometimes the best way to provide health care sometimes does car us to overrun. You could try to space out your appointments and get less people, but sometimes it is going to happen; it is unfortunate. So, I guess I could relate to him and explain to them why this is the case and apologize for taking up time.

**Category: Resident states what his/her reaction is NOT. It seems like the resident is striving to meet an ideal whereby she/he must deny any negative reactions to patients.**

003R

He is a tough guy. [This comment was made just before I asked question #6.]

[In describing his reaction, 003R seemed to describe how he treated him or responded to him rather than what his personal impression of the patient may have been.] I think I've been fair to him. I don't think I get mad at him or say anything to provoke him even more. I tried to calm the situation down.

[Question: How would you go about trying to calm the situation?] Try to go back and explain to him that it is not my decision, but it is not our intention to gang up on him. I try to explain to him further about the health care system and how the primary care doctors do what they do and the specialist do what they do.

011R

From my standpoint, this is something I guess we expect sometimes with patients, especially when you are warning them of something that could be dangerous or which can have a dangerous impact on their lives. Patients generally tend to be frustrated and there is some element of denial initially, that is one of the first responses to disease or illness.

Reaction-wise, if you ask me my personal reaction, it would just be, I would just stay calm. I would not overreact. I would not be angered. I would not be frustrated from a clinician standpoint that here I am trying to aid the patient, trying to determine the cause of his problems and the patient is kind of ungrateful. I would not be involved with all of those feelings.

013R

He is such an angry guy. It is unexpected. I do not react surprised. I don't think I would be angry.

**Category: Resident's reaction is solely about the patient: 1) Figuring out patient dynamics and working with those; 2) Content to identify patient problems, but not determine how to work with those.**

### **1) Figuring out patient dynamics and working with those**

001R

Investigator used the word "visceral" and 001R stated that he hasn't heard that term in a long time and tries to keep everything in "lay terms"

My gut reaction to the second response is of a man who still needs help, still a man who needs to be empowered in his care, still a man who you need to try to get the point across of "I am in a position to care for you. I'm not a heart doctor, but I am still in a position to care for you."

And in addition to the empowering, he would say to the patient, "In the next few days or few weeks, there are things you can do that will help me help you."

005R

Overall, at this point, I would call him quote, a difficult patient.

There is a problem that I see that needs to be addressed and he all of a sudden he sees me as, "You're going to solve all of my problems. You're there for me, I can call you anytime I want and I'm great." And, if they don't agree with what you want to do, they can be a little more combative. If you don't give them medicine for their problem when they want it that is when the combat begins. They say, "You just want to make money off of this. How much it is going to cost." This is a difficult patient to try to help first of all.

Second of all, I would just make sure I have a good rapport with this person because he may have a problem going on. You don't want him to be angry when he leaves this place because there may be an actual cardiac problem going on. So, make sure that despite how he feels or how he acts or talks to you, tomorrow he could be a different guy. I don't know what the situation is at home or that he may be angry that day. That is the best part about them coming back to see you. They make an appointment; they may leave the office angry, but you make an appointment in two weeks and he shows up. Now, obviously in his mind you are seeing that this person wants to be helped because he comes back. He sees you as somebody who can help. If he didn't, he wouldn't come back, "I [the patient] wouldn't come back to that guy [the doctor]. Why should I? He didn't do anything."

I think he is a difficult patient initially. There are some problems there to address, not just cardiac. I think he has a bad history with doctors before because he mentioned, "How much is that going to cost me now?" Obviously he has been charged before by somebody else over something that has been done. I just want to investigate later on what other medical problems he might have.

008R

I think he's confrontational, hostile, irrational. He needs to go to anger-management.

But, like I said, I would still try to get at why is he so angry.

[Question: So you don't have a problem or hesitation confronting the anger, finding out what is going on there?] No. You should find out what is going on. He may really have ... maybe he tried to seek us out before and all he got was a big bill and nothing and didn't get any follow-up, maybe nobody ever called him back, that happens.

[Question: So, you want to know if his anger is valid or not?] Yes.

015R

He's frustrated and I understand that. If he's been sitting there for a while and had to pay \$10 to get into the parking garage, I understand that these folks are human just like anybody else and can snap when placed under pressure. And this guy just seems to be a very ... probably has a controlling personality, tries to stay on-top of things and is feeling a little bit frustrated and helpless: "You're not able to fix it" and is lashing out.

[So, the controlling part is compensating for his helplessness?] No, I am saying that he probably has a controlling type personality, likes to be in charge and he is not in charge. [I am wondering if that can be exacerbated in times when you are feeling helpless? That you become more controlling of your environment to compensate for this inside feeling of "what in the world is going on here"] Well, yeah, absolutely, I mean you try to hold on to the control. Absolutely. But, it is a ... when you realize, you know in medicine you are not in control when you're sick or have some type of physical ailment, your body is in control. And, whenever he, inside he has that understanding, but it is a great source of anxiety that "I cannot just fix this."

## **2) Content to identify patient problems, but not determine how to work with those**

002R

Goodness. He is somebody that you know is going to be difficult.



He is somebody you “may end up firing from your practice.”

She would try to get to the bottom of the anxiety before determining if she would be able to work with him or not. [I asked what getting “to the bottom of the anxiety” would look like.] She noted that she would first validate his physical complaints and then discuss that the need to “find out why there is a physical problem.” [Here it seems that finding the answers to the physical concerns (what is unknown) is the way to alleviate the anxiety (but is it her anxiety or his anxiety she is relieving?).]

004R

[Initially he seemed to be having a hard time trying to figure out what to say: “I’m trying to find the words to describe it.”]

In a way, it’s kind of humorous because he has been waiting 2.5 hours and we kind of suggest this is what needs to be done and then he kind of gets upset and says, “I have to go see another doctor. You’re trying to gang up on me.” If he really wasn’t that concerned about it or he didn’t want to have anything else done, why did he really come here in the first place?

You could make it a lot easier on him and say, “Well, maybe this isn’t chest pain. Try this and come back if it gets worse.” But, I don’t think that is the appropriate thing to do in this case. Considering that you are going to have to find some way to try and convince him to get the stress test done.

But, again, it is up to him. The final decision is going to be made by him. Which, in this case [referring to the tape], he just says, “Well fine, let’s do it.” Not the exact response you want from a patient, but some patients are like that I guess.

007R

He seemed to be a very demanding, overbearing at times, very argumentative.

I would be very suspicious about this person.

I have never come across somebody as belligerent as he: to just basically assume certain things about the clinic, about me, and so forth.

I would be very cautious as far as keeping this person as a patient.

Certainly, this is his first time here. I would do the best to provide a service for him. I would certainly document our interaction on paper or dictate what the conversation was about. Express that he was a very overbearing, angry person.

Whether he wanted to have this stress test done, I would probably either refer him to another physician for continuity of care. I certainly wouldn't want this guy as my patient because of the way he is.

009R

That guy's reaction or my reaction? [Your reaction to him.] My reaction to this, what do I think of this patient? [Yes.] I think he is angry, sometimes unreasonable, uncooperative.

## APPENDIX AB

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 3 V2Q7

3. What are some themes suggestive of how resident primary care physicians respond to a statement characteristic of personality disorder-type (guarded/argumentative type) characteristics and processes?

*Vignette 2, Question 7*

*Prompt: What kind of feelings did this patient evoke in you?*

**Category: Resident indicated no reaction/no feelings evoked by interaction.**

003R

[Question: You said you wouldn't get mad at the patient, but did any feelings come up at all, like feeling defensive?] No. I just feel that he is a little more aggressive and I think that he doesn't trust the system and he is very guarded.

005R

I don't want to say feelings of anger at all.

I don't want to say sympathetic, but empathetic. I do feel for him. "You might be going through something you don't understand and I'm here to help you." I don't want to be apathetic, I want to be hopefully ... to trust and believe that he has this pain. I'll do different things to try to get this thing resolved somehow or another to do the best to my ability to do what I can to do that. I am not going to be able to solve any problems personally, but, "Who can I send you to so you can get those problems addressed?" Not to really solve them, just address them. Person with back pain, "We are going to send you endocrinologist [not sure about that last word]." Or a person with nerve damage, we'll send to a neurosurgeon, a neurologist. I know who to send you to. They come here with this pain, "I don't know what to do doc." You as the doctor should know, "OK, I can have it worked up by somebody or something else." A lot of it is just management of the disease. But, I don't feel any resentment towards him because he is hurting and that is where his pain comes from.

008R

None.

011R

No, I would not have any ... if you talk about, like if I would be emotionally challenged: no. But, it would be a demanding visit in the sense that I'd be maybe a little exhausted. It would be more that: exhausting than demanding.

[Question: But you wouldn't feel anxious or ...?] No. No anxiety, no feelings of anger, no feelings of frustration, no feelings of helplessness, no.

013R

None.

014R

Well, I felt a little bad about him having to wait 2.5 hours. It is unfortunate that we have to take up somebody's time like that unnecessarily.

[Question: But no kind of emotional response?] Like anger or defensive? [Yes.] Not really. I don't really get upset about stuff like that. Not really. I guess no anger.

**Category: Resident provided insightful response indicating an awareness of his/her own reaction/feeling. Some are positive and some are negative ways of responding, but provide an awareness nonetheless.**

001R

“There was the tension.”

“There was confrontation.”

“There was the implication of inadequate care or the potential for inadequate care.”

Question: When you recognize those feelings inside, what do you do with that information? It registers, and recognize there is tension and confrontation, how do you utilize that information in the way you work with somebody?

I'll take a deep breath. I'll let them continue venting. I don't want it to come down to an argument or a shouting match or 'I'm the medical authority in this room and you need to listen to me.' It shouldn't be that way. I don't like it to be that way.

I try to redirect the patient to stay on target. By the end of the conversation on tape, that was a good comment that they were getting away from the point.

006R

I don't like those kinds of situations. They make me nervous.

But, I don't feel personally responsible for them. Other than, my biggest response is ... When I see something like that, I would like to have an academic way to face it by having those little tools so that I don't have to go personal, it doesn't have to be personal.

[Question: You talk about having those tools so it doesn't have to be personal. Are you saying that you're ignoring your own affective response to the patient or do you use that information somehow, if you feel yourself becoming nervous or guarded or offensive or argumentative, hateful towards the patient? What do you do with that type of feeling?] Well, I am human. There is no way of denying that I could have those types of feelings. So, what I try to do is to intellectualize them by realizing that I am putting myself in a position of dealing with a wide group of personalities, a wide group of the public, it is not my fault, and I'm not going to be effective with everyone, and that I would like to have this little box of tools to know how I am going to react when I have this person so that I could kind of go into that mode.

007R

Well, he is just a very suspicious character. He probably has some secondary gain in his future care here.

I would be concerned whether he's approached other physicians in similar fashions. Whether he's had similar relationships with other physicians or, probably how many relationships he's had or how many clinics he's gone to and so forth. If I was out in solo practice, I would certainly try to inquire where else he's been and so forth. Has he been in any litigation proceedings towards other doctors?

[Question: But, were there any feelings that you had towards him? Did you notice yourself becoming tense or angry or sad for him? Did you have any type of emotional response to him?] Well, I mean, certainly you're going to be very defensive just because somebody is being on the offensive. You certainly, I mean sometimes in making yourself angrier or speaking louder would make the situation worse. I would try to be as calm and as collected as possible just so that he knows that he's not making headway or he's basically trying to break me to the point to where ... I'm just concerned about the situation. I would just try to be as calm, collected and try to go through the process and try to provide him what he needs. Certainly, in some situations, there are times that I get angry, too. And that is not unusual for people to be angry with this type of person, but that just may make the situation worse.

010R

Unappreciated.

Annoyed.

In some ways, nervous and intimidated.

When asked what 010R would do with these emotional reactions, he stated that he would recognize them in order to delay saying something too quickly. He noted that not recognizing these emotions may result in responses driven by these exact emotions. However, to know that they are there allows him to monitor them and react in a better way that builds a relationship.

010R also noted he is more likely to put the problem on the table rather than ignore it. That is, he would rather explore the anger and find its meaning rather than avoid it.

012R

[Question: So you mentioned the anger. Did you have any other type of emotional response to him?] You know, I have a lot of empathy, a lot of emotions towards a lot of patients. But, patients like that I don't.

I'm sorry, but this is probably my own experience with patients. I am a person who you approach me nicely, you take everything on my body. I mean, my shirt, my shoes, you take anything you want. But, you approach me with that kind of voice, you are not going to get anything. Basically, you are going to get what I think you are going to get. And, you take it or you leave it.

**Category: Resident's reaction may be characterized by being stressed or anxious (frustrated). Response shows a more limited self-awareness.**

002R

This is somebody who is going to be difficult.

I had some anxiety in myself. [I had to specifically ask what she was feeling inside of herself in order to get this response.]

Her own anxiety was related to a need for more information and that she has not had that much experience with this type (i.e., difficult) of patient.

She noted that she does not want to get drawn into a confrontation.

004R

[The investigator actually asked if 004R had an "emotional response" to the patient.]

Yes. I thought the doctor did a decent job of dealing with it

You know, you can ... with some patients you can apologize all you want and they are still going to get upset with you. Some patients you can explain every little detail and exactly why you want to do this or that and whatnot, but they are still going to get upset and sometimes just ... Sometimes comes down to just asking, "Well, I need to know ... I need a decision from you. We need to come to some point of agreement as to what we are going to do next."

[Question: So, would you say you were mad also or frustrated with him?]

I would say I was frustrated with him, yes.

On one hand, I can kind of see why he would be upset if he waited 2.5 hours to be told he needed another test, but that sometimes is just how it works out, especially in a walk-in clinic or something like he was saying he went to.

009R

[Question rephrased: Did his style, the things he said, the way he presented, cause you to have any type of emotional response to him?] Yes. It could.



[Question: How would you describe that? While you were sitting there watching him, did you feel yourself becoming ... what?] Become stress. I wouldn't argue. I don't think arguing would solve the situation.

015R

Well, I can understand his frustration.

[You weren't feeling angry?] I was not angry at him. I understand his point of view. Of course, we all like people that just are nice and kind and listen, which he is not of that persuasion. I would probably say that I would react to him, frustrated. [You could get frustrated?] I could identify with his feelings.

## APPENDIX AC

## CATEGORIES FOR FOCUS OF INQUIRY RESEARCH QUESTION 4 GQ1

4. What are some themes characteristic of resident primary care physicians' thoughts about working with patients with personality disorder-type characteristics and processes in primary care settings?

*General Question 1*

*Prompt: What are your thoughts about working with patients with personality disorders in a primary care setting?*

**Category: Resident is willing to deal with personality disorders, but also recognizes limits and would refer/consult.**

001R

In reference to a patient I have, this goes back to I need to see you every month until we have got a better handle on *all* of your problems. You [his patient] can leave a message with me any time. If it's a situation that requires medication, then there needs to be frequent follow-up on the medication.

Question: Instead of distancing, it sounds like you want to approach the patient?

Yes, I want to be approachable. I don't know if they are going to be a good friend and I am going to give them a hug. They might be. But I want to be more than just 'he's my doctor', I guess there is a level of friendship.

003R

"As primary care, we have to take care of them [patients with personality disorders], too. So we try to do our best to take care of the personality side. And to the point where we see that it is beyond our care or if care becomes too complex, and at that time I would refer to psychiatrist. But I would try to take care of the personal problems."

[Question: Would you address those personality issues with them ?]

I would.

[Question: How would you go about doing that?]

Ask him why does he feel this way about all physicians. What experience specifically did he have in the past that caused him to be not be trusting the medical profession. I would tell him to go in to details and tell what event, what triggers his emotions.

004R

[In addition to the above statement, I asked, "What is primary care's role in working with patients with personality disorders in a primary care setting?"]

I think the first step is knowing that many of your patients are going to have personality disorders. I think when you first meet patients and suspect that they have personality disorders you don't want to label them too much, but I think it is definitely one of those factors that is used in making a decision about how you are going to treat this person.

I think asking other physicians how they would deal with borderline personality disorder patients.

Sometimes setting rules or guidelines. Not that you would tell the patient, "I am setting rules with you," but being very direct with them and saying ... of course it depends on the disorder.

006R

I think it is part of the game. There is no way you can avoid it.

From my little experience that I have. I am always dealing frequently with, for example, women, married women, who have abusive households. They don't come in and immediately tell you that. She is going to come in with some kind of somatic complaint.

This morning, I was with an orthopedist and he was saying, "I hate these people. They come in, these older people who come in all the time thinking that I can make them younger again. They got this pain and that pain and they just can't accept the fact that they are getting older." And, I said, "Well, they are probably here more for a little t.l.c." And, he said, "That is why I became an orthopedist and I didn't go into psychiatry." I said, "Well, there is no way you would make it in family practice."

So, I think it is definitely a role that family physician has to be aware of that psychosomatic diseases are real. In other words, it is as legitimate a problem as coronary artery disease.

007R

I think it depends on the comfort of the physician. Whether they want to deal with these issues.

I think there is an advantage to deal with these people in having a relationship with them to the point where they feel comfortable with you just because you'll be able to better serve their other medical problems. It's not like going to a specialist and he having to deal with just one aspect of their medical situation. Certainly, he can easily go to a psychologist and a psychiatrist and have them deal with this problem. But, if he's coming to you for something as simple as a cold or as difficulty as cancer, or something, you're ultimately going to have to deal with his psych issues. And, that is in any kind of relationship, whether it is going to be a specialist or a family physician. The majority of the time, you are going to see these people on a daily basis. Or, at least more so than the other specialists. Since you are the one who is going to be making the referrals to these people, it would be at least nice for the specialist to know how this person is, instead of just getting this patient and he being the way he is and not knowing" "Hey, why did you send me this patient? I don't know what the heck is wrong with him, but he certainly has some psych issues." You want to be at least courteous to the people you are going to refer these people to. Certainly, having a relationship or at least a rapport with your patient, that is certainly going to dictate the type of practice that you have. In these cases though, certainly get some kind of social or psych professional to at least help me with the situation to at least get a better idea of how to deal with these types of people.

013R

[I added: Is primary care an appropriate place for working with these patients?] I think so. But still, I would get advice from a psychiatrist or a psychologist, I would consult and then I would feel more comfortable.

[Question: What is your understanding of what a personality disorder is?] It depends. People with different personality disorders can present differently. I think my mother-in-law has borderline personality disorder: sometimes she loves you, sometimes she hates you (laughing). Sometimes, like Bi-Polars, things are difficult, not difficult, but it can be an unusual presentation. I try to get opinions from people who are trained to take care of personality disorders.

[Question: What do you think are some common traits of personality disorders?] Sometimes they have depression, sometimes manic, sometimes aggressive, there can be flight of thought, or flat affect. They have difficulty keeping a relationship. They have difficulty relating to family and to friends.

014R

I think it is essential I guess because: 1) you are (as the primary care doctor) the first person they see, you have to differentiate, that is the first thing you have to do, you have to make sure the first time you see them that they don't have anything else about them, you have to be sure that you do address their physical needs or physical problems and then as well at the same time you have to in the back of your head whether this person has along with physical or not even physical but may just be mental problems and if you do this you can treat them or refer them.

015R

Well, we're the first line of defense. They come into the office and you initially have to build a camaraderie with them, especially with these personality types. And, they don't necessarily have to like you, they have to at least trust you. Once you get to that point, you can start suggesting counseling. But, if they come in the door the first time you see them and they lash out like this guy and you say, "I think you need counseling," he's out the door and you'll never see him again. You need to be the first counselor that ever gets involved in his life. As a primary care physician, you are not going to be able to spend an hour with every borderline personality that comes into your office. Most family physicians aren't trying to do so either to give that kind of counseling, but once you have some kind of relationship, you can start working that in.

[So the relationship is the important part?] Yes. [Establish the trust and then be able to steer them in another direction?] It's, "I'm not crazy" would be the response. "I didn't say that you were, but we all have trouble some time and we all need a little bit of help, so help us." [So, it's a collaborative process: "help us".]

**Category: Resident seems to perceive a limited role in dealing with personality disorders and prefers to refer.**

002R

We [primary care] are the first to see these patients and can serve as an access to mental health services. If I have a relationship with them, then I may be able to refer them for psychiatric help.

[I asked what having a “relationship” meant.] A relationship may exist after the 2<sup>nd</sup> or 3<sup>rd</sup> visit. She did not feel that she could refer someone to psychiatric help in only the first visit. She would tell the patient that the doctor (psychiatrist) would be someone who could also be of help to him.

005R

I don't really feel comfortable completely about direct, overlooking of the care for the patient medicine-wise. So, I would probably refer them to someone like MHMR or like another professional like a psychiatrist for an evaluation and see what they recommend.

I would love to have them in my practice still. As long as somebody else is following for their psychiatric medication or for BiPolar ...

Personality disorders, again, I am not too up to date in the care of that style of person.

I would adhere to have a psychologist or psychiatrist involved in that treatment.

If they [psychologist or psychiatrist] think they are stable, I'll make sure they [patient] follow up with their psychiatrist.

008R

You have to deal with everything that walks through the door.

[Question: Is there a role in primary care specifically for addressing personality issues?] Yes, they have medical needs, too.

[Question: Would you work with the personality concerns?] You can't change a personality. Maybe a little bit, but not necessarily. It depends on how it affected the doctor-patient relationship. If it was something that, I mean we get lots of patients that

are in there and are, “Hurry up; I’m going to leave, blah, blah, blah.” I pretty much just let it roll off, if they want to leave, then leave.

[Question: It sounds like you take everything at face value?] Yes. If you want to leave, then leave because I’ve got 10 other patients behind you. I might even explain that when they come in here, we think it is going to be a 10 minute visit, but it ends up taking an hour and the same thing happens to other people. When you need the care and you don’t want me to say, “Your 10 minutes is up, I have another patient.” Some patients take a little longer.

[Question: Do you feel like you have to adjust your style at all, or do you try to stay pretty consistent from patient to patient?] I adjust my style. [Question: How would you describe that?] Try not to be confrontational. It just ruins my day. I try to stay focused on just their medical care and really the personality is beside the point.

I can sit here and say that right now, but if I were in an agitated mood and they get me then, who knows. Each day is different for everyone.

[Question: It was interesting to me is that you had no problem addressing the patient’s anger whereas others don’t want to deal with the anger.] It happens. But, if I had 30 patients out there and I only had time to see 10 of them, and this guy is just sitting here and arguing and arguing, using up his time, I would say, “We’re not getting anywhere today at all. If you want to go somewhere else, then go somewhere else. I’ll talk with the nurse, and we’ll set you up with someone else.”

009R

Identify the patient and proper referral.

[\*\*Question: How would you define a personality disorder?] If they either say you are very good or they say you are very bad. Extremes. They are very insecure, very demanding. Have unstable emotions, unstable social relationships, unstable jobs. Difficult personality. Difficult interpersonal relationships.

010R

010R described working in a primary care setting as a “different situation.” He stated that he, “can’t take the luxury of dealing with these types of patients.” He noted that if he had his druthers, he would take more time and address these emotional concerns, but that he has been deterred from doing so by some faculty.

He went on to describe what he believes family medicine’s mission is. He believes that family physicians should be prepared to deal with problems in each of the following areas: pediatrics, medicine, ob/gyn, surgery and psychiatry, as well as community and

public health issues. He stated that as problems become more specific or intense in each of these areas, then the specialists in those areas should address the concern. However, because patients are human, their problems will most likely not be specific to one concern, but will encompass emotional concerns as well. Again, physical and emotional pain are seldom completely separate, but each may be accompanied by the other to varying degrees.

012R

Pretty good. Very good because, specifically, I can witness to that more than any other resident here. I worked in Houston for 2 and ½ years before I came here. I did internal medicine. And, then I am doing another board in family medicine. You can tell the personality of Houston patients is a little different than Bryan/College Station. In Houston, they come in and they are very questioning. They want to know everything you are doing and why you are doing it. Very educated. You ask them about, you tell them, “I am going to do a stress test on you” and the next time they come in with an article from the internet and with their own interpretation. And we deal with that without any problems and they usually listen to us. And here (in Bryan/College Station) it is the other way around. You ask them to go do it (having the stress test) and they do it and they come back and then you tell them whether it is bad or good and it doesn’t make any sense to them. And they keep going with their life style. It used to be that if you ask them to quit smoking and to do their exercise test or whatever and they would do it. Here, if you tell them to quit smoking and to lose weight then you don’t see them again. I’ve dealt with these 2 types of personalities and haven’t had any problems. I wouldn’t refer people to psychiatry because we have access to medication, we know what they do and we know how they can and cannot help. I think we see a great deal of people with psychiatric illness, most of them depression and anxiety and those are very well treated in our clinic. Now, schizophrenia and other types of psychiatric illnesses I would refer. Such as anorexia and bulimia and stuff like those are very hard to treat, but the most common ones we see are anxiety and depression and I’ve never had any problems. (Went on to describe a patient he had who was depressed. He put her on medication and she was improved and said to him, “I’m doing great thanks to you, doc.”)

[Question: How would you define what a personality disorder is? What are the types of things you look for in somebody with a personality disorder?] Well, I tend to believe that personality disorders are not per se not inborn personality disorders. They are inherited from families. People tend to have the personality of the parents or the guardians that they spend more time with. I look at my personality as very, very similar to my dad’s and my brother’s. And, my wife’s personality is very, very similar to her mom and dad’s and her brothers’ and sisters’. And, I completely believe in that case. It is an acquired thing rather than an inherited thing.



Personality disorders are very, very hard to deal with because usually they show up later in life and then if you are used to doing this type of thing for the rest of your life, if you try to change it, it is very hard.

[Question: If it is engrained like that, how do you work with somebody? Are there things that you need to change about yourself in working with them? What approach do you take?] Of course, it is not going to be my major problem because I am going to be seeing this patient once a month. The goal is to treat the patient so he can deal with the outside world such as his friends, his wife, his parents. And, that takes a great deal of help. To be honest with you, I don't have the right answer for that. I don't. Sometimes, you just do your best and things don't work.

## APPENDIX AD

## RESIDENTS' RESPONSE STYLES BY INTERVIEW QUESTION

001R							
	Patient Complaint Oriented	Not Self-Aware			Self-Aware		Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2							X
V2Q4				X			
V1Q10	X						
V2Q10							X
V1Q6					X		
V1Q7					X		
V2Q6			X				
V2Q7					X		

002R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2							X
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10							X
V1Q6		X					
V1Q7		X					
V2Q6					X		
V2Q7		X					

003R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10							X
V2Q10							X
V1Q6						X	
V1Q7		X					
V2Q6		X					
V2Q7		X					

004R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2							X
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10							X
V2Q10	X						
V1Q6		X				X	
V1Q7							
V2Q6		X					
V2Q7						X	

005R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2							X
V2Q4	X						
V1Q10							X
V2Q10							X
V1Q6		X					
V1Q7						X	
V2Q6		X					
V2Q7		X					

006R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2							X
V2Q4	X						
V1Q10	X						
V2Q10	X						
V1Q6		X					
V1Q7						X	
V2Q6						X	
V2Q7						X	

007R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10							X
V2Q10	X						
V1Q6		X					
V1Q7		X					
V2Q6		X					
V2Q7						X	



008R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1							X
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10	X						
V1Q6		X					
V1Q7		X					
V2Q6		X					
V2Q7		X					

009R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2	X						
V1Q3	X						
V2Q1							
V2Q2							X
V2Q4				X			
V1Q10							X
V2Q10	X						
V1Q6		X					
V1Q7		X					
V2Q6		X					
V2Q7						X	

010R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2							X
V1Q3	X						
V2Q1							X
V2Q2							X
V2Q4				X			
V1Q10	X						
V2Q10							X
V1Q6						X	
V1Q7						X	
V2Q6						X	
V2Q7						X	

011R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10							
V1Q6		X					
V1Q7		X					
V2Q6		X					
V2Q7		X					

012R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10							X
V1Q6						X	
V1Q7						X	
V2Q6						X	
V2Q7						X	

013R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2							X
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10							X
V1Q6						X	
V1Q7		X					
V2Q6		X					
V2Q7		X					

014R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1	X						
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2	X						
V2Q4	X						
V1Q10	X						
V2Q10							X
V1Q6		X					
V1Q7		X					
V2Q6						X	
V2Q7		X					

015R							
		Not Self-Aware			Self-Aware		
	Patient Complaint Oriented						Patient Dynamic Oriented
				Neutral			
V1Q1							X
V1Q2	X						
V1Q3	X						
V2Q1	X						
V2Q2							X
V2Q4				X			
V1Q10	X						
V2Q10							X
V1Q6						X	
V1Q7		X					
V2Q6		X					
V2Q7						X	



## VITA

James Deegear  
 4202 Camber Court  
 College Station, Texas 77845  
 (979) 690-9595

## ACADEMIC EXPERIENCE:

- |             |   |
|-------------|---|
| 2003 – 2004 | Internship in Psychology<br>Student Counseling Service (APA Accredited Program)<br>Texas A&M University, College Station, TX<br>Primary Clinical Supervisors:<br>Kerry Hope, Ph.D.; Ted Stachowiak, Ph.D., ABPP   |
| 2000 – 2004 | Doctor of Philosophy<br>Counseling Psychology (APA Accredited Program)<br>Texas A&M University, College Station, Texas<br>Dissertation Title: Understanding How Primary Care Physicians<br>Work with Personality Disorder Patients: A Qualitative<br>Approach |
| 1993 – 1995 | Master of Arts<br>School Psychology<br>Trinity University, San Antonio, Texas<br>Thesis Title: Executive Functioning: Mentally Retarded Juvenile<br>Delinquents   |
| 1988 – 1992 | Bachelor of Arts<br>Major: Philosophy<br>Washington and Lee University, Lexington, Virginia<br>Thesis Title: Free Will and Intent: When are We Responsible for<br>Our Actions?  |